Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4, 2009 8:00 A September Helen H. Smith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Potomac 9801 Kendale Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 85 Dec. 31, 1923 Washington, DC Director 578-20-8079 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 🖾 No Director Maryland | Montgomery Potomac 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must obes. 20854 United States by Funeral 9801 Kendale Road Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Tile and Marble Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ္ Leona M. Grier Edward Stevens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9801 Kendale Road, Potomac, Maryland 20854 Valerie Williams/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Potomac United Methodist
Church Cemetery 20c. Location - City or Town, State 20a. Method of Disposition September 9, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 Donation 5 Dother (Specify) Potomac, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licensee M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 7201 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. E. let Ur Jerning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1

Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☒No 24a. Was an autopsy performed? 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

Nelson Kalil, M.D. 29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5454 Wisconsin Avenue, \$1300, Chevy Chase, Maryland 20815

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

31. Date filed (Month, Day, Year) State 08 2009

29b. Signature and title of certifier

29a. Certifie

(Check only one)

Medical

32 Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person.

31. Date filed (Month, Day, Year)

Salgzar

David Strnit

eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

	-	For State Registrar	State of Maryland		rtment of F ctificate of			giene Reg. No.	10 05
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Rita		Slor	man		2. Date of Dea Month Sept.		3. Time of Dea 9 6:10 p
Examin		4a. Facility Name (If not institution, give s 1330 Broening	Highway		Balti			4c. County o	
Funeral Director		5. Social Security Number 220-22-6531 Usual Residence of Decedent	7. Age (In yrs. I	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 10-14	, Year) -1930 F	9. Birthplace (State or Fo. Country) Pennsylvan:
Maryland -f show	tor	10a, State 10b. County		,Town or Lo					10d. Inside City Li
with the 3a or 28a	Funeral Director	10e. Street and Number 1330 Broening	Highway		10f. Zip Code 21	224		10g. Citizen of WI	
d within 72 hours after death with the Maryland gjene. er than "natural", or items 23a or 28a-f show , the Wedjeal Evanings must be mailled at	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	I2. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of H fYes, specify Cub 1 □Yes 2 ☑ No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		American Indian, white, etc. White
within 72 hours afterene. than "natural", or i	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life. l	dent's Usual Occup kind of work done DO NOT use retire	pation during most of word d)	king	16b. Kind of Bus	
e filed al Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)	Ct			1	ne (First, Middle,	Maiden Surname	
d 2 should be the and Mental the and Mental 7 is marked o traumatic eve	ဥ	Gaetano 19a. Informant's Name/Relationship (Ty)	Stavo oe. Print)		ng Address (Street	Maria tand Number or Ru	ral Route Numb	Dubono er, City or Town, S	
is 1 and 2 of Health s item 27 is rother tra		Arthur Sloman 5 20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 □ R	20b. F	Place of Dispo	sition (Name of		Date	20c. Location - 0	. Md. 2122 City or Town, State ore, Mary
permit. Page Department of Important: If any injury of ance.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		22	2. Name and Addre	ess of Facility Jo	seph 1	N. Zann	ino Jr. F. . Md. 2122
Physician and Medical Examiner be executed street the prival-transit street british the prival s	dical Examiner	23a. Part 1. Enter the desase, or complishock, or heart failure. List only or Immediate Cause (F haldisease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to consequence). Due to (or as a consequence). Due to (or as a consequence).	uence of:					Onset and Dea
e death certi he attending ied for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregpant in the past 12 mg/fths? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	I death 3	☐ Ectopic pregnan☐ Other (specify)			23d. Date Mor	e of delivery nth Day Yea
uires that the signed by the detach	þ	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying cause gi	iven in Part I.			ribute to the cause of deat 3 ☐ Probably 4 ☐ Ink
ian: The law requir rtificate has been s tor, page 2 should	Completed						24a. Was auto perfe 1 □Yes	psy ormed?	Were autopsy findings ava prior to completion of caus death? I ∐Yes 2 ☐No
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ng Mffel	ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Wo	ury at ork? □Yes 2 □No		how injury occurre	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, st fy)	reet, factory, office			(Street and Numb wn, State)	er or Rural Route Numbe
e Hospir 24 hour e Funera letely fills	Medical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowner: On the basis of examinating and manner stated.	owledge, dea ation and/or in	th occurred at the nvestigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time	e cause(s) and ma , date and place,	anner as stated. and due to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier			29c. Licer	nse number US 7465		29d. Date signed	d (Month, Day, Year)
3		30. Name and address of person who con N.S. Ryapakiem, D.	ompleted cause of death (Itel 25 MG/N 3 32.7 esistrar's Signa	m 23a) (Type,	Print) iffe 200,	, Reisters	town,	MD. 2	1136
Sta Registr		31. Date filed (Month, Day, Year)	32. Penistrar's Signa	ature	a del				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** OPTEMBOR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner EUNDAL RIVE Hours Min. 8. Date of Birth (Month, Day, Year) 09/02/1923 Birthplace (State or Foreign Country) If Under 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Days Months **№** M 2 🗆 F Yrs 377-32-0415 86 Hong Kong Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b County 10c. City, Town or Location 28a-f show Evaruinar coast by notified at 1 ☐ Yes 2 No Director Millersville MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ö 21108 541 Point Field Drive United States items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🗽 No Specify: Specify: Asian ģ 3 Widowed 4 Divorced Completed th and Mental Hygiene.
T is marked other than "natur traumatic event, the Medical 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Professor Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hok Nin Tung ဂ Sheung Yee Ho 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. 7109 Rivers View Court Columbia, MD Leslie Tung – son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/08/2009 Hanover, MD Ardent Crematory 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licenses M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that callised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** NAL MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PERTENS, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burialattending physician for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) the 9 Unknown cate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 P No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 2 No 1 ☐ Yes 25. Was case referre o medical examiner? 26. Place of Death (Check only she) Be Other: 4 \(\sum \) Nursing Home Hospital: 1∐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Natural 5 Pending investigation 1∐Yes 2∐No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and addre Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Day Marcena Mae Truelson 27, 2009 August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Suburban Hospital Montgomery

9. Birthplace (State or Foreign Country)
Ohio Bethesda 8. Date of Birth (Month, Day, Year) June 21, 1912 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Hours Months Days 1 ☐ M 2 🕱 F 97 Yrs. 265-34-1457 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Maryland Montomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5721 Grosvenor Lane United States 20814 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛂 No White Specify: Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Claude Wesley Allen Lela Betts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John B. Kincaid/Friend 4920 Niagara Road #104, College Park, Maryland 20740 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kinsman Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition Kinsman, Ohio 1 □xBurial 2 □ Cremation 3 □ Removal from State 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Marvland 20814 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic-nse. M01498 Lorg 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2⊿No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred Manner of Death Natural 5 Pending

attending physician and for use as the burial-transi Division of Vital Records, P.O. Box 68760 ryelson, Marcena funeral director, To the Hospital or Attendli within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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Medical

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Physician/Me	IF FEMALE: 23b. Was decede in the past 1 1 ☐ Yes 2 9 ☐ Unknow
Ş	Part II. Other sign
Completed	
To Be (25. Was case refeexaminer? 1 ☐ Yes 2
ification:	27. Manner of De 1 Natural 2 Accident 3 Suicide 4 Homicide
<u> </u>	4 LI HOMICIGE

29a, Certifier

(Check only one)

State Registrar

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite "Madical Examination" is ust be notified at

Physician

/Medical

Examiner

3altimore, Maryland 21215-0036

EMALE: Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29b. Signature and title of certifier See, mo

and manner stated

29c. License number D0057124 29d. Date signed (Month, Day, Year) 8128109

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

investigation 6 Could not be determined

Troung Bao, 10110 Molecular Drive, #205, Rockville, Maryland 20850

31. Date filed (Month, Day, Year) **SEP 08**



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	1	For State Registrar	State Of	iviai yiari		ertificate of		10 101		Reg. No.		2.8	505
D 1		1. Decedent's Name (First, Midd	dle, Last)						2. Date of De Month	ath Day	Year	1	of Death
Physicia /Medica		ROSA		VASI	MA				SEPTO	naez	7,2000	7 6	30 /TM
Examine	er	4a. Facility Name (If not institution				4b. City, Town,			~	4c. C	ounty of Dea	th	
		JOHNS HOPKING	6. Sex	7. Age (In yrs. I	ast birthday			Hrs.	8. Date of Bir	th		thplace (Stat	e or Foreign
uneral irector		219-40-6397 Usual Residence of Decedent	1 □ M 2 反 F	92	Yrs.	Months Days	Hours	Min.	(Month, Da 10/14			aly	
MO M	-	10a. State 10b. Count	Location							City Limits			
a-f st	cţo	MD		В	altin	nore					1X∑Yes 2 ☐ No		
3a or 28	Funeral Director	10e. Street and Number 1300 S. Elw	ood Aveni	ue		10f. Zip Code 10g. Citize 21224 USA					zen of What Country?		
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Mackeal Examiner is ust be refilled at once.	<u></u>	11, Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed For	1 □Yes 2 X No			Hispanic Origi pan, Mexican, Specify:	n? (Spe Puerto I	ecify Yes or No Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			,
natur	Completed	15. Decede (Specify only high	ent's Education lest grade completed)		16a. Dec	edent's Usual Occu e kind of work done DO NOT use retire	pation during most o	of workir	ng	16b. Kind	d of Business	/Industry	
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ental Hygie ed other t e event, III	Be	17. Father's Name (First, Middle	e, Last)				18. Mother		(First, Middle	, Maiden S	Surname)		
nd Me mark imatic	2	19a. Informant's Name/Relation	nship (Type. Print) 🗗	ciend	19b. Mai	ling Address (Stree	t and Number	or Rura	l Route Numb	oer, City or	Town, State,	Zip Code)	
altha 27 is er trau		Lillian Smit			6120	Oakhil	l Dr.	El	dersb	urg,	MD 21	784	
ent of He nt: If item ry or othe		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		State Mos	Place of Dispendence of Ho	position (Name of ematory or other pla ly Rede	emer9		/2009		ation - City o		•
Departm Importal any Inju once.		21. Signature of Funeral Service Massoc &	e Licensee			22. Name and Add	ess of Facility	Jos	eph N	. Za	nnino	Jr.	FH 1224
ysician Medical aminer	Examiner	23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of):									Approxi Interval Onset a	mate Between nd Death	
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this co	မ	1 Yes 2 No		Inpatient 2		ient 3 1 DOA			me 5 Re			pecify)	
th. : After : funera	tion:	27. Manper of Death 1 Natural 5 Pend 2 Accident inve	ding 28a. Date (Morstigation	of Injury oth, Day, Year)	28b. Time Injury	/ W	puryat ork? □Yes 2 □N		28d. Describe	e now injury	y occurred		
within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Cou	ld not be 28e. Place	e of Injury - At h ling, etc. (Speci	ome, farm, fy)	street, factory, office	9		28f. Location City or To	(Street and own, State)	d Number or	Rural Route	Number,
24 hours e Funeral letely fille	Medical C	29a. Certifier 1 ✓ Certifier (Check only one) 2 ☐ Medic	ying Physician: To the cal Examiner: On the I and mar	e best of my kno basis of examina oner stated.	owledge, de ation and/or	eath occurred at the investigation, in m	time, date an y opinion, dea	d place, th occur	and due to the	ne cause(s) e, date and	and manner place, and d	as stated. ue to the cau	use(s)
withir To th comp	Me	29b. Signature and title of cert	trus			De	nse number 06 1115			SEP	e signed (Mo		
\		30. Name and address of pers HAROIN A. PAN	on who completed cau	se of death (Ite	m 23a) (Typ	e, Print) ENN AUE	INUE	BA	LTIMO	mi,	ms ·	21226	1
Sta Registr		31. Date filed (Month, Day, Ye SEP 0 8 2	32. 1 109 Server	Registrar's Sign	gar	le!							

Physician /Medical **Exam** Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "redical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 thours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director mans of the completely filled in by the completely f

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ial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner
as the bu	Medical
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242-18-8484 Usual Residence of Decedent		90			$\perp 03/13/1$	919	NC
10a. State 10b. County	10c. Ci	ty, Town or Locat	tion				10d. Inside City Limits
	Wa	shington	1				1 ☐ Yes 2 ☐ No
10e. Street and Number	Wa		10f. Zip Code		10	g. Citizen of What Co	untry?
Toe. Street and Number			101. Zip 00de			9 . • =	,-
4724 10th St NE			2001			SA	dense to dise
11. Marital Status	12. Was Decedent Ever in U Armed Forces?	lf Y	s Decedent of F es, specify Cub	lispanic Origin? (S an, Mexican, Puerl	pecity Yes or No- to Rican, etc.)	14. Race - Ame Black, White	
1 ☐ Never Married 2 ☐ Married	1 ☐Yes 2 ☐ No6-0]Yes 2. XNo	Specify:		Specify:	
3 XWidowed 4 Divorced	Year or Dates: 7-1.	3-1955				B:	ack
15. Decedent's Ed (Specify only highest gra		16a. Deceder	nt's Usual Occup and of work done	ation during most of wor		6b. Kind of Business/	Industry
	College (1-4or 5+)	life. DO	NOT use retire	d)		HG 6	4
12th grade		Speci	lal Poli			US Govern	nent
12th grade 17. Father's Name (First, Middle, Last)	!			18. Mother's Nar	ne (First, Middle, M.	aiden Surname)	
Dallas Vaile	2.5			н	attie Bar	nes	
19a. Informant's Name/Relationship (19b. Mailing	Address (Street	and Number or Ri	ural Route Number,	City or Town, State,	Zip Code)
Terri Vailes/da	anohter	4724 1	Oth St	NE Washi	ngton, DC	20017	
20a. Method of Disposition	20h I	Place of Dispositi	ion (Name of	1		0c. Location - City or	Town, State
1 🖾 Burial 2 ☐ Cremation 3 ☐	Hemoval from State	cemetery, cremat	tory`or other pla	i			
4 ☐ Donation 5 ☐ Other (Specif	TID	Nat, Ce	emetery			aurel, MD	
21. Signature of Funeral Service Licer	isee	22. N	Name and Addre	ess of Facility M	arshall's	Funeral l	lome
Fulia 1: 1	Nasshall	421	17 9th S	t NW Was	hington,	DC 20011_	
23a. Par . Enter the disease, or com	plications that caused the deaf	th. Do not enter	the mode of dyi	ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between
shock, or heart failure. List only Immediate Cause (Final							Onset and Death
disease or condition resulting in death)	α.	Renal I	ailure			,	21 days
	Due to (or as a consec					1//	00 1
Sequentially list conditions,	b. Inani			^	1 //	- WINER	30 days
cause. Enter Underlying	Due to (or as a conse)	Mieuce of		-G	TION APPROVED BY N	EDICAL EXAMIT	
Cause (Disease or injury that initiated events	c. Demen				APPROVED BY "		
resulting in death) Last	Due to (or as a consec	quence of):		CERTIFICA	House		
	_d						
		-					
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn					23d. Date of de	livery
in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of		Ectopic pregnan Other (specify) _	cy		Month	Day Year
9 Unknown	9 🗆 Unknown						
Part II. Other significant conditions of	contributing to death but not res	sulting in the unde	erlying cause gi	ven in Part I.	23e. Did tob	acco use contribute t	the cause of death?
_					1 □ Ye	s 2 X No 3⊟P	robably 4 thinknown
					24a. Was ar autopsy	v prior to	utopsy findings available completion of cause of
					perform 1 □ Yes 2	ned? death?	_
25. Was case referred to medical				26. Place of De	ath (Check only one		
examiner? 1 X Yes 2ENo	Hospital: 1 ☐ Inpatient 2 ☐	TER/Outpatient	3□ DOA Ot	ner:		nce 6 ☐Other (Spe	ecify)
27. Manner of Death	*	28b. Time of	28c. Inju	ry at	28d. Describe ho		
"Tanatural 5 Pending investigation	28a. Date of Injury (Month, Day, Year) 06/19/2009	9:40 p	. M	rk?]Yes 2. X iNo	Fall at	Nursing Fa	cility
2 Accident investigation 3 □ Suicide 6 □ Could not b		1				reet and Number or F	
4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci Wilson Heal	ify)	Contar		City or Town	, State)Asbury	Methodist
11						Gaithersbu	
29a. Certifier (Check only one) 1 △ Certifying PI 2 ☐ Medical Example Certifying PI	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death o ation and/or inve	occurred at the testigation, in my	ime, date and plac opinion, death occ	ce, and due to the ca curred at the time, da	ause(s) and manner a ate and place, and du	is stated. e to the cause(s)
29b. Signature and title of certifier	and mainter stated.		29c. Licen	se number	29	9d. Date signed (Mon	th, Day, Year)
D. This	1 18-11	ماد	Do	33299	g,	eptember 3	2009
yours !	1. Williams				36	-bremper 3	, 2007
30. Name and address of person who							
	11iams DO 3720		St NW Wa	ashingtor	, DC 200)18	
31. Date filed (Month, Day, Year) SEP 08 2009	32. Registrar's Sign	bark	0				
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State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 28, 2009 **Physician** August 6:00pM Sylvester Williams /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PG Clinton Bradford Oaks Nursing Home 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 578-14-3082 100 06/30/1909 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ ... any injury or other traumatic event. 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State XXYes 2 □ No M R3 Temple Hills Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20748 I ISA 6015 South Gate Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2XX Married 1 ∐ Yes 2 🙀 No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Private. 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unav inav မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6015 South Cate Drive: Temple Hills, Maryland 20748 Shirley Dean - Williams (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/04/2009 Beltsville, Maryland Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee 4594 Beech Road; Temple Hills, Maryland 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shrick, or heart failure. List only only cause on each line. Approximate Interval Between Onset and Death Immediate Chuse (Final Advanced age Physician disease andition resulting in death) /Medical Due to (or as a consequence of): Examiner Atrial fibrilation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Congestive Heart failure requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Failure to thrive Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) P.O. s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has page 2 s 2 X No 1 □Yes 1 ☐ Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendii 4 hours after death. death. filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified D0052999 Culldy m

State Registrar

SEP 08 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

2014 G-6; Clinton, MD 20748

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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44. Facility having of contractification per several and examined: La Plains La Plain	And		an/	Decedent's Name (First, Middle,Last)					Month	Day Year	3. Time of Death 0911 hrs
Security Nurses Size Size	vieu	iicai Exami		4a. Facility Name (if not institution, give str	eet and number)			ocation of Deat		4c. County of Dea	th
This Street and Number The Street and Number				Social Security Number 6. Sex		Mo			_	Fore	irthplace (State or ign Maryland ountry)
The Sevent and Number 100 Zep Code Top Citizen of White Courtery's T	1			10a. State 10b. County							
Second Content of Part Par	2	yland I-f show	후		W		Zip Code		11	0g. Citizen of What Co	721
Second Second Content	6	the Mar 3a or 28a otified at		3072 Heathcole Road			20602				District Control
23a. Fight Enter the disease, or chrippleations that caused the death. Do not enter the mode of dying, such as cardied or respiratory street, shock, or heart fibred. List only one cause of water the death of the cause of the death of the cause of th		er death with or items 2:		1X Never Married 2 Married	Armed Forces? Yes 2 XNo	If Yes, sp	ecify Cuban	Mexican, Puer		White, etc.	
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23a. Fight Enter the disease, or chrippleations that caused the death. Do not enter the mode of dying, such as cardied or respiratory street, shock, or heart fibred. List only one cause of water the death of the cause of the death of the cause of th		Saltil ermit. epartm nporta njury o		21. Signification of Funeral Service Licensee	0 0 1 1 1			1.			
The composition of the composition of course of sections (Plant Sections (Plant Sections)) The composition of the course of sections (Plant Sections)			_	23a. Fartil. Enter the disease, or complica	tions that caused the death	h. Do not enter the mo	Beech Finder of dying,	such as cardia	ole Hills, or respiratory ar	Maryland 2 rest, shock, or heart	Approximate Interval
The state of the s		Medical		Immediate Cause (Final disease	Multiple In	njuries					
The contribution of the contributing of death but not resulting in the underlying cause given in Part I. Contributing to death but not resulting in the underlying cause given in Part I.						- 0.					
Section of the control of the cont			nine	cause. Enter Underlying Cause							
290. Signeture-and the or certifier O.C.M.E. August 20, 2009 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		ited J ansit	Exa	events resulting in death) Last Due	e to (or as a consequence o	of):					
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290. Signeture-and the or certifier O.C.M.E. August 20, 2009 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		the Hospit hin 24 hour the Funer		29a. Certifier (Check only one) 2 Medical Examiner: C	To the best of my knowle	edge, death occurred	at the time, o	late and place, n, death occurre	and due to the ca	use(s) and manner as	stated.
30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		To with To	Med	29b Signature and little of certifier	nd manner stated.	060				1	
Tiotal Troods and Tiotal Troods							l		MD 21201		
Registrar SEP 0 2008 Courts 15.				31 Date filed (Month Day Year)	32 Registrar's Signa						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 16 35 PM **Physician** SEPTEMBER BALPH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** JOHNS HORKINS BANVIEW MEDICAL CENTOR BALTIMALE
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-15-1954 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Country) MD 12XM 2□ F Yrs. 54 214-62-8728 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐XYes 2 ☐ No Director Dundalk Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 7823 Collingsham Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 | Xes 2 | No If Yes, Give Year or Dates:Vietnam 1 ☐ Never Married 2 ☐ Married 1 □Yes X\□No Specify: Specify:White δ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welding Maintenance 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Hume Herbert G. Wiliams ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13107 Eastern Avenue, Baltimore, MD 21220 Ruth Boothe - Sister Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Baltimore, MD 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 9-5-09 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Bradley-Ashton Funeral Home 2134 Willow Spring Road, 21222 21. Signature Juneral Service Ligens e 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 22 DAYS INFARETION MYOCARDIAL disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peripheral vascular disease, kidney-failure Completed 24b. Were autopsy findings available prior to completion of cause of death? DIABETES, GOT BLEEDING, GRAM - NE GRATIVE autopsy performed? 1 □Yes 2 ☑No 1 ☐ Yes 2 ☐ No ROD SEPSIS 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1□Yes 2☑No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 1 ☐Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed P.0. Records, Division of Vital

Funeral

Director

28a-f show

23a

? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Experient is ust be notified at

72 hours after

12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r

Pages 1 and 2 s ment of Health ar ant: If item 27 is

permit. Pages 1 an Department of Heal Important: If item 2 any injury or other

Physician

/Medical

attending physician and for use as the burial-transit

signed by the a d be detached f

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e Funeral Director: A letely filled in by the fu

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other t

Maryland 21215-0036

altimore,

within 2 MY1

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 08 2009

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) FITEMBER 3, 2009

30. Name and authors of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

EASTERN AVENUE BALTIMONE, MD 21224

32. Registrar's Signature

The law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, Hospital or Attending Physician: To the !

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 10:00 A.M Williams 08 28 2009 Ernest /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Mitchellville Villa Rosa Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** Months Days Min. Hours 1⊠M 2□ F 79 Yrs. 04/30/1930 Director 232-42-7801 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show ed other than "natural", or items 23a or 28a-f shover the Modical Examinar must be notified at 1 X Yes 2 □ No Director Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20720 Funeral 12700 Truths Promise Ct. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or iten any injury or other traumatic event 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) UPO Driver 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Addie Toliver Raven Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Scott (Son) 12700 Truths Promise Ct. Bowie MD 20720 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood MD 4 ☐ Donation 5 ☐ Other (Specify) 9/4/2009 Fort Lincoln Cem. 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th St NW Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hours Acute Myocardial Infarction disease or condition resulting in death) Due to (or as a consequence of): Atherosclerotic Cardiovascular Disease years Se uentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2★★ 0 24a. Was an autopsy performed? Yes 2224No 's after deau.

ral Director: After this ceru...

'n hy the funeral director, pe 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Marsing Home 5 Residence 6 Other (Specify) Hospital: 1 ∐ Yes 2**X⊡X**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1

✓ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a
To the Funeral L **ExCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature title of certified September 2, 2009 D32261 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 9500 Annapolis Road Lanham, Maryland M.D. Richard J. Feldman, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 08 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Ye ar Month 12:50 PM **Physician** 08 31 2009 Samuel Lewis Washington Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Takoma PArk Sligo Creek Nursing Home Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday **Funeral** Min. Months Days Hours 1 X M 2 □ F Yrs 12/30/1927 DC 81 579-28-1637 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, "In "Medical Examinating is ust by natified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinating at 1 Yes 2 □ No Director Prince George's Hyattsville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA 6220 20th P1. 20782 Was Decedent Ever in U.S.

Armed Forces?

13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?)

1★Yes 2□No 1-10-1970

15(Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 1 Married 1 □Yes ·2 🖾 No If Yes, Give Year or Dates: 9-30-1970 Specify: Black ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 3 years Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henrietta Scott ဂ Samuel L. Washington, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6713 14th St. NW #203 Washington DC 20012 Lucille Washington/ Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. Maryland Veterans Cem. 9/18/2009 Cheltenham, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses 4217 9th St NW Washington DC 20011 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed Parkinson's Disease and burial-tra Due to (or as a consequence of): physician s the burial Physician/Medical Systemic Hypertension attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Ye ar in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) P.O. 1 the hed 9 I Unknown 9 Unknown à been signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 1 ☐ Yes 2 ☑No 2 XINo 1 □Yes ospital or Attending Physician: The hours after death.

uneral Director: After this certificate y filled in by the funeral director, par 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Other: 4XXNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 31, 2009 D46998 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Steven Tee, M.D. 7525 Carroll Avenue Takoma Park, Md.

State Registrar 31. Date filed (Month, Day, Year)

Steven Tee, M.D.

32. Registrar's Signature 08 2009

Baltimore, Maryland 21215-0036

Box 68760,

State of Maryland / Department of Health and Mental Hygiene

		-	1 - State Registrar Cer	rtificate of Death		g. No. 1119 28513
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Septemb	
· A	/Medic	al .	Regina Wessel 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2eh cempi	4c. County of Death
and the	Examin	CI	Spring House-Westwood	Bethesda	1011	Montgomery
	Funeral Director		5. Social Security Number 213-20-6781 6. Sex 1 M 2 K 89 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Sept 19,	9. Birthplace (State or Foreign Country) 1919 Maryland
	and ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	e Mary la-f sh	ctor	MD Montgomery Bethe			1 □ Yes 2 □ No
	with th	Dire	10e. Street and Number 5101 Ridgefield Rd., Spring House-Westwood	10f. Zip Code 20816	10	g. Citizen of What Country?
	filed within 72 hours after death with the Maryland thygene. Hygene. The than "natural", or items 23a or 28a-f show ent, the Mudical Evant for mat be naithed at ent, the Mudical Evant for mat be naithed at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 3 □ Married 1 □ Yes 2 □ Vo	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
9036	ours af	by	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 □Yes 2 🔯 No Specify:		Specify: White
15-0	hin 72 ho e. an "natur Medical	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)		6b. Kind of Business/Industry
212	d withir giene. er than	Som	Elementary/Secondary (0-12) College (1-4or 5+) Var	ious Banking Posti	ons	Banking
and	e d dal	Be	17. Father's Name (<i>First, Middle, Last</i>) William B. Mullen	18. Mother's Nam	e (First, Middle, M. C.	laiden Surname) Wall
Maryland 21215-0036	d 2 should be f th and Mental 7 is marked of traumatic eve	은		ng Address (Street and Number or Rui	ral Route Number,	City or Town, State, Zip Code)
, M	27 i		<u> </u>	7 Burdette Rd., Be		MD 20817
Baltimore,	T of of		1	Valley 9/5/		Timonium, MD
Balt	permit. Pag Department Important: I any injury o once.		Ma WIIIam G. Dau	1050 York Rd., low		on Funeral Home, Inc. 21204
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	ter the mode of dying, such as cardiac	or respiratory arre	Approximate Interval Between Onset and Death H
	Examiner					
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
°, 20,	tificate be executed g physician and as the burial-transit	I Examiner	that initiated events resulting in death) Last c Due to (or as a consequence of):			
68760,	ificate g physi as the k	ledical	d			
O. Box	ath cer attendin or use	Physician/M		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
ds, P.	uires that the de n signed by the a Id be detached t	þ	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tob	oacco use contribute to the cause of death?
Records,	he law requir e has been s ige 2 should	Completed			24a. Was ar autops perform	y prior to completion of cause of death?
ital	ian: T ertificat ctor, pe	Be Co	25. Was case referred to medical examiner?		1 □ Yes 2 th (Check only one	
of Vital	ding Physician: The I n. After this certificate ha funeral director, page	ျ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie			ence 6 Other (Specify)
ion	nding ath. r: After e funer	ation	1 _ atural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	Work? M 1 □ Yes 2 □ No		
Division	al or Attendi s after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (St. City or Town	reet and Number or Rural Route Number, n, State)
./	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal of the control of the pass of examination and/or in and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)
5	To the within 2 To the comple	Med	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)
			Im (www	139456		9/1/09
			30. Name and address of person who completed cause of death (Item 23a) (Type	5530 Wiswusi	LAVE	9/1/09 nd 20815
	Sta Regist	ate	31. Date filed (Month, Day, Year) 32. Pegistrar's Signature,	5530 chevy c	111	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year Latasha D. Young 2009 4c. County of Death N/A Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Samaritan Hos Birthplace (State or Foreign Country) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7 / 27 / 7 4 5. Social Security Number 7. Age (In vrs. last birthday) 1 □ M 2 1 F Months Days Hours Min 35 216-86-0177 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Baltimore N/A XXYes 2 □ No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 512 Roberts Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 [X]No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, African 1 ☐Yes 2 🔀 If Yes, Give Year or Dates: Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Ämerican 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Telephone Elementary/Secondary (0-12) College (1-4or 5+) Clerk 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roslyn Fauntleroy C. Ernest Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1400 E. Madison Ave-Apt. 707, Balt., MD 21205 Roslyn A. Winston/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Hanover, MD 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 9/4/09 Ardent Crematory 4 ☐ Donation / 5 ☐ Other (Specify) 21. Signature of Juneral Service Lice 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd,Balt.,MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACQUIRED IMMUNODEFICIONCY SYNDROME disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 110 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 LINO 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, signed by the a After this certificate has funeral director, page 2 s after death Director: d in by the f within 24 hours aft To the Funeral Di completely filled in

Physician

Examiner

Funeral

Director

28a-f show

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or items 23a

"natural"

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy Injury or other traumatic event, Ite Magnee.

Physician

/Medical

Baltimore,

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

/Medical

Registrar

31. Date filed (Month, Day, Year) State

29a. Certifier

29b. Signature a

(Check only one)

and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

SEPTEMBER 2, 2009 031136

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9005 KILBRIDE AD, BARTIMORIF, MG 21236 mo Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10e, perFH, G895, 9/8/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 200 00 wa 20 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, gilve)street and number) Examiner BALTIMORE NORTH OAKS NURSING HOME Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 6-12-80 10 M 20 F 9 RUSSIA 08-18-1919 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State in than "natural", or items 23s or 28e-f show the Medical Examinat must be notified at 1 Yes 2 No MD BALTIMORE Director BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe #106 2120 4.5 WILSO N MI Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 □ Vidowed 4 □ Divorced ģ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than " College (1-4or 5+) Elementary/Secondary (0-12) OFFICE MANAGER **HEALTH & FITNESS** other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be and Mental F 9 SARAH KASASCHKOFF MORRIS SHULMAN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a MONROE ZEFFERT/SON 15 WOODHOLME AVENUE, BALTIMORE, MD 21208 Pages 1 and 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition OHEB SHALOM or other place) 5 permit. Page Department o Important: If eny injury or once. 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State ö 09-04-2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) MEMORIAL PARK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 weeks **Physician** /Medical Due to (or as a consequence of) **Examiner** Par Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 No ğ 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ₺No this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury ₩ Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation hours after death uneral Director: 2 Accident completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 - Homicide within 24 hours a To the Funeral 1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 2,2009 037573 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reisterster Mawi 57. 25 MD ZIBEL Sef 32 Filasistrar's Signature 31. Date filed (Month, Day, Year) ----State SEP 08 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	ne or maryiaria	-	tificate of E			g. No.	305	285	5 6
	- · · ·		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	Year	3. Time of D	
	Physicia /Medic	al .	Nancy Jo Anderson					August 30	2009_		7 AM	М
	Examine	er	4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or l			Calv	y of Death		
المسجد والمس			4019 South Shore Ave. 5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	Port Repul	If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birth	place (State or	Foreign
	Funeral Director		236-66-3876 1□ M 2		Yrs.	Months Days	Hours Min.	Aug 5 194	2	West	Virginia	
	pu ,		Usual Residence of Decedent	100 City	Town or Loc	ation					10d. Inside City	y Limits
	arylar shov	ò	10a. State 10b. County Maryland Calvert	Toc. City,		t Republic					1 □Yes	2 🕅 No
	the N 28a-f	rect	10e, Street and Number			10f. Zip Code		10	g. Citizen of	What Cou		
	3a or	Funeral Director	4019 South Shore Ave.			206	76		Unite	ed Stat	es	
	ems 2	Iner	11. Marital Status 12. W	as Decedent Ever in U.S. med Forces?	13. V	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp. n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - Ameri ack, White,	ican Indian, etc.	
20	be filed within 72 hours after death with the Maryland Hylgiene. d other than "natural", or items 23a or 28a-f show event, I is in a dich Exacinate or collified at	by Fu	1 ☐ Never Married 2 ☑ Married 1	□Yes 2[v]No ∕es, Give		∐Yes 2∐No	Specify:		Spec	ity: whi	ite	
იაიი-ი	hours	ed b	15. Decedent's Education (Specify only highest grade com	ar or Dates:	16a. Dece	lent's Usual Occupa	ation	1	6b. Kind of	Business/Ir	ndustry	
<u> </u>	hin 72 e. an "na M dh	Completed		ollege (1-4or 5+)		kind of work done d OO NOT use retired;	uring most of work)					
7	ed wit	Con	12		hom	emaker	18. Mother's Name		own hor			
	be d d	Be	17. Father's Name (First, Middle, Last)					Marie Lewi		ine)		
Z	should be filed within and Mental Hygiene. s marked other than umatic event, the Man	မ	Michael F. Sharpolisky 19a. Informant's Name/Relationship (Type. P.	intl	19b Mailir	ng Address (Street a				n, State, Z	ip Code)	
<u> </u>	v = 10 3		George D. Anderson-husba	nd	4019 S	outh Shore	Dr. Port Re	epublic Mar				
e,	ss 1 ar		20a. Method of Disposition	20b. Pla	ice of Dispo	sition (Name of natory or other place n Funeral S	J Aug 31 20	99 A	20c. Location Lexandr			
Ĕ	Pages ment of ant: If ite ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	al from State MELT							3 ———	
Бант	permit. Pages 1 and 2 Department of Health s Important: If item 27 Is any injury or other tra		21. Signature of Funeral Service Licensee	cl	44	2. Name and Address 05 Broomes	is of Facility Rel. Is. Rd. Por	rt Republic	MD 200	676		
			23a. Part 1. Enter the disease, or complication shock, or heart fallure. List only one call	ns that caused the death.				1.0			Approximate Interval Bety	
-	Physician		Immediate Cause (Final disease or condition			Ventr	icular	tach	rano	lia	Onset and D	rutes
À	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	Corona	aut			C	4 . 50	
	11.5	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	ence of):	Coronar	7 41	70	u w		90	CVE
	cuted hd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c									
Ď,	icate be executed physician and s the burial-transit	I Ex	resulting in death) Last	Due to (or as a conseque	ence of):							
6876U	tificate be executed g physician and as the burial-transit	edical	d									
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	death cer ne attendir ed for use	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ Ho	☐ Live birth 2☐ Fetal of Dregnant at time of de ☐ Unknown		☐ Ectopic pregnance ☐ Other (specify)	y 			Month	Day	Year
٦. O	at the d by th etache	Phy	9 ☐ Unknown Part II. Other significant conditions contribu	-	ting in the u	nderlying cause give	en in Part I.	23e, Did tol	bacco use co	ontribute to	the cause of c	death?
ds,	w requires that the d been signed by the should be detached	d by	diabetes mo	- A A /	ho	nic pla	struck	e 1 2246	s 2 □ No	3 □ Pr	robably 4 🔲 I	Unknown
Records,	w requ	Completed	lune discaso,	huserte	ousd	n site	PO/AB MOG	24a. Was a		b. Were au	topsy findings	available
	ician; The law certificate has b ector, page 2 sl	dwo	chronic anx	Tie				autops perform 1 ☐ Yes	med?	death?	completion of c 2 □ No	cause or
VIta	ilan; i ertifica etor, p	BeC	25. Was case referred to medical examiner?					th (Check only on				
	hysic this ce at dire	မ	1 Yes 2 → Hospi	1 Inpatient 2 E			4 🗀 Nursing H	ome 5 Reside			cify)	
Z D	iding Physician; th. After this certifici funeral director, p	ion	1 → Matural 5 ☐ Pending	Ba. Date of Injury (Month, Day, Year)	28b. Time o Injury	Worl	yat k? Yes 2 □No	28d. Describe ho	ow injury occ	Julieu		
Division of	Attending Physician: or death. ector: After this certific by the funeral director; I	fical	3 Suicide 6 Could not be	le. Place of Injury - At hor	me, farm, st			28f. Location (S	treet and Nu	mber or Ri	ural Route Nun	nber,
2	al or safter	Certification:	4 ☐ Homicide determined	building, etc. (Specify,	,			City or Tow				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the fi	Medical	(Check only 2 Medical Examiner:	n: To the best of my know On the basis of examinati and manner stated.	vledge, dea ion and/or i	th occurred at the ti nvestigation, in my o	me, date and place opinion, death occu	e, and due to the during at the time, of	cause(s) and date and plac	d manner a ce, and due	s stated. e to the cause(s	s)
	To the within To the Comple	Me	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date sig	gned (Mont	th Day, Year)	
			1. 7	2013		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	3952: Frede	2	8/	3//	07	
			30. Name and address of person who comple	ted cause of death (Item	23a) (Type	Print)	Frad	1	11	1	201	ナロ
			1. 1-6045 110	BURLIOU	NCI.	rr.	1 1 600	JUCK.	, 101		. OB	/ (
	Sta Registr		31. Date filed (Month, Day, Year) 8 20	32. Registrar's Signat	ure A	fords	1 1 600	moe,	, 101		.06	/ 4

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 11:40 PM 2009 August STACEY LAVERIA BOWIE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** If Under 24 Hrs. Frederick Frederick Memorial Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Davs Hours 1 □ M 2 🔽 F 43 213-82-7737 Sept 13, 1965 Maryland **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or Items 23a or 28a-f show the Wedical Examiner must be notified at 1√Yes 2□No Director Maryland | Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 USA 1413 Key Parkway Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Black 1 ☐ Yes 2√XNo Specify. Specify: δ. 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mailing facility Mail handler permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vivian Brown Donald L. Bowie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21702 1744 Worthington Court, Frederick, Maryland Vivian Bowie - mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8-22-2009 Frederick, Maryland Resthaven Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Sinature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 Maron amelle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) eas Cancer **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-tran Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 🗆 Ectopic pregnancy Month Day Year fo 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐Yes ျှ 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28b. Time of Certification: 28a. Date of Injury 28c. Injury at Work? (Month, Day, Year)

execute Box 68760. certificate be Hospital or Attending Physician: The law requires that the death of thours after death.
Funeral Director: After this certificate has been signed by the atten P.0. Division of Vital Records, funeral filled in by the 24 hours a

72 hours after death with the Maryland

filed within

Baltimore, Maryland 21215-0036

5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide

29a, Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

MDD65443

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 W 7th Street, Frederick, Maryland Elena Iarikova, MD

State Registrar

completely

To the I within 2

Medical

31. Date filed (Month, Day, Year)

32. Pegistrar's Signature Barks

			For State Registrar	State of Maryla		rtificate of L		rılai myglei Reg.	C 3 - C	28518
P	hysicia	an	1. Decedent's Name (First, Middle, Las Gilberto	Iglesias	Benit	cez	2	Date of Death	2/009 Year	3. Time of Death 0 9 4 0 M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Beth	Location of Death		4c. County of Death Montgor	nery
	uneral rector		5. Social Security Number 6. S		rs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min. A	Date of Birth (Month, Day, Ye pr. 20, 1	9. Birthp 952 E1 S	place (State or Foreign htry) Salvador
ъ		tor	Usual Residence of Decedent		City, Town or Lo	Spring				0d. Inside City Limits 1
with the I	3a or 28a	Funeral Director	10e. Street and Number 10 Ivywood Co	urt		10f. Zip Code 2090) 4	10g. T	Citizen of What Cour El Salva	ntry? dor
5-0036 72 hours after death with the Maryland	"natural", or items 23a or 28a-f show odeal Eventiner I. ust be netfilled at		11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ∐Yes 2 ▼No If Yes, Give Year or Dates:			spanic Origin? (Speci n, Mexican, Puerto Ri Specify; Lvadoran		14. Race - Ameri Black, White, Specify:	
	d other than "natur event, the Medical	Completed by	15. Decedent's Ed (Specify only highest gra	de completed)			ation during most of working ()		o, Kind of Business/In	
d 2121 filed within Hygiene.	her than		Elementary/Secondary (0-12)	College (1-4or 5+)	Ele	ectricia	18. Mother's Name (Electrica	al Work
arylanc should be fil and Mental H	rked ot tic ever	To Be	17. Father's Name (First, Middle, Last, Carlos Iglesi				Marina B	enitez		
end 2 shout ealth and N	27 is ma r trauma		19a. Informant's Name/Relationship (Delfina Velaso	Type. Print) wife/ uez de Igle	19b. Maili	ng Address (Street)	and Number or Rural 1 700d Cour	t Silve	er Sprin	g,Ma20904
Ore Jes 1 tof H	- 0		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specia	Removal from State C	n. Place of Dispo cemetery cre emetery cre	osition (Name of matory Gother place 10 General	al 8/26/	2009	Santa To El Salva	own, State ecla, ador
Balti permit. Departm	Important: any Injury once.		21. Signature Funeral Service Lice	fold:	1					E,P.A. g,Md20910
Dhu	alalan.	W A	23a. Part1. Enter the Isease, or comshock, or heart failure. List only Immediate Cause (Final				ig, such as cardiac or	respiratory arrest	,	Approximate Interval Between Onset and Death 2 days
) /M	sician edical miner		disease or condition resulting in death)	a. Cardioge: Due to (or as a cons Aortic pa	sequence of):					1 week
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68760, ificate be executed	g physician and s the burial-transit	edical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	sequence of):					
O. Box (he death cert)	by the attending ph tached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	☐ Ectopic pregnand	у		23d. Date of deli	very Day Year
S, P.	gned oe de	by Ph	Part II. Other significant conditions			underlying cause giv	en in Part I.		cco use contribute to	the cause of death?
ecord law requir	hould	Completed	hypertension end stage rea		•			24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
n: The	certificate has l rector, page 2 s		25. Was case referred to medical				26. Place of Death		d? death? XXNo 1 ☐ Yes	2 🗆 No
f Viii	ils cert directo	o Be	examiner? 1 Yes 2 1\lambda No	Hospital: 1X Inpatient 2	2 ☐ ER/Outpatie	ent 3 DOA Oth	or:		ce 6 □Other (Spec	cify)
ono ding Ph	After th funeral	ion:	27. Manner of Death 1X Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year	r) 28b. Time (Wor		8d. Describe how	injury occurred	
Division of Vital Records, P. I or Attending Physician: The law requires that tafter death.	To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Certification: To	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	De 28e Place of Injury - A	I At home, farm, st ec <i>ify)</i>			8f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
e Hospita	e Funeral letely fille	Medical C	29a. Certifier (Check only one) Certifying P Certifying P Medical Exa	hysician: To the best of my miner: On the basis of exan and manner stated.	knowledge, dea nination and/or	ath occurred at the tinvestigation, in my	ime, date and place, a opinion, death occurre	and due to the cau ed at the time, date	use(s) and manner as e and place, and due	stated. to the cause(s)
	To th comp	Me	29b. Signature and title of certifier	050	50	29c. Licens	se number		Date signed (Month	_
3			30. Name and address of person who	completed cause of death	(Item 23a) (Type	p, Print)	68 4+ 4	-	8/18/2	00
			Michael P.Si	egenthaler 32 Registrar's Si	M.D.	8600 01	d George	town Rd	Betheso	a,Md20814
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 21 20			eres				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Aug 29, 2009 **Physician** 11:40pm Burton E. Doris /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland Golden Living Center Date of Birth (Month, Day, WAPT 21, Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Yea Funeral Days Hours 1□ M 2□√ 220-18-3618 83 Director Usual Residence of Decedent 10d. Inside City Limits 10b. Count 10c. City, Town or Location 10a State 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examinar must be modified at 1 □Yes 2 □ No Allegany Cumberland MD Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number death with 21502 USA 512 Winifred Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or Iter 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Saltimore, Maryland 21215-0036 Specify: Specify. white <u>ک</u> 3 → Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Schmidt Henry Schmidt ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 1032 Keyser WV 26726 19a. Informant's Name/Relationship (Type. Print)
Benjamin Burton Jr. Department of Health ar Important; if item 27 is any Injury or other trau once. son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/30/2009 MD Scarpelli Funeral Home, P.A. Cresaptown 4 ☐ Donation 5) ☐ Other (Specify) 21. Signature of Functal Service Little 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Sonset and Deal Immediate Cau e (Final disease or condition resulting in detrin) monly Cerebro Vase **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician use as IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year for in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 28d. Describe how injury occurred funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 □Yes 2 □ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29c. License number 29b. Signature and title of cer

State Registrar

31. Date filed (Month, Day, Year)

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3

DIL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D0033280

KENT AVE. CUMBERLAND, MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar		. ,	Cer	tificate of l	Death	R	eg. No.	2005	20520
ı	Dhuaiais		1. Decedent's Name (First, Middle, Las						2. Date of Dea Month		20 OYear	3. Time of Death
	Physicia /Medic			Crawford				Land Dark	August		2009 ounty of Death	9:20 A M
	Examin	er	4a. Facility Name (If not institution, give 3411 Island Creek				Silver S	Location of Death	1		tgomer	У
<u>*/</u>	Funeral Director		5. Social Security Number 6. St 162–22–7400		(In yrs. last t	oirthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Nov 9,	1929	Cou	place (State or Foreign ntry) sylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	cation					10d. Inside City Limits
	Maryla -f sho	to	MD Montgome	erv	Silve	r Spi	cina					1 □Yes 2 🕍 No
	n the	Director	10e. Street and Number	-1			10f. Zip Code			10g. Citize	n of What Cou	ntry?
	ath wit	ral	3411 Island Creek				20906			USA	D Ansaul	and Indian
326	is flied within 72 hours after death with the Maryland il Hygiene. other than "natural", or items 23a or 28a-f show vent, in Medical Eventiner ruist be cylling at	by Funeral	11. Marital Status 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	Ր947 – 49	9 1	Was Decedent of H fYes, specify Cuba I □Yes 2【XNo	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		. Race - Ameri Black, White, pecify: Whi	etc.
5-0036	2 hou	sted	15. Decedent's Ed	ucation		a. Deced	dent's Usual Occup	ation during most of wor	kina 1	16b. Kind	of Business/Ir	ndustry
2	ithin 7 ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	`life. L	00 NOT use retired istrator	i)	_	Foder	ral Cov	ernment
2	filed w Hygie other t		17. Father's Name (First, Middle, Last)		FX	JIII LII	ISCIACOI	18. Mother's Nar	ne (First, Middle,			CETHICITE
an	Ild be fental rked o	To Be	Russell Franklin H		ord			Vera Joh	nson			
Maryland	nd 2 shou alth and M 27 is ma l		19a. Informant's Name/Relationship (Barbara G. Crawfor		1!	9b. Mailir 3411	ng Address (Street Island C	and Number or Ri reek Cou	ural Route Numbert Silve	er, City or T er Spr	own, State, Zing, M	p Code) D 20906
altımore,	t. Pages 1 and 2 should be filed w riment of Health and Mental Hygie rtant: If item 27 is marked other t njury or other traumatic event, in		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place ceme inal Jo	of Dispo tery, cren	sition (Name of natory or other place y Cremat	cory 08/	Date 21/09		oine, M	
Baltı	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Liger			Ĝ	oling and Addre	s cremati	on Servi			x 784 e, MD 21029
-	Physician	8 1	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	the death. D	o not ent						Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Acuto La Due to (or as								18 months
	Examiner	-	Sequentially list conditions,	b. Due to for so	o consequence	o o o o o o						
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease o, Injury that initiated events	Due to (or as	a consequenc	зе от):						
,	icate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as	a consequenc	ce of):						
68760,	ate be hysicia he bu	Medical		d								
O. Box 68	eath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal dea	ath 3[☐ Ectopic pregnand ☐ Other (s <i>pe</i> cify) _	су		23	d. Date of deli Month	very Day Year
σ.	N requires that the dispersion is been signed by the should be detached	þ	Part II. Other significant conditions of Myelodysplastic St	-	ut not resulting	g in the u	nderlying cause giv	ven in Part I.				the cause of death?
Records,	e law requ has been le 2 shoult	Completed							24a. Was autor		24b. Were au prior to death?	topsy findings available completion of cause of
	sician: The law s certificate has l lirector, page 2 s		25. Was case referred to medical					26 Place of Do	1 □Yes ath (Check only o	2 X No	1 ☐ Yes	2 🗆 No
5	/sicia s cert	o Be	examiner? 1 Yes 2 XNo	Hospital:	ent 2 □ ER/	/Outpatie	nt 3 DOA Oth		Home 5X Resi		□Other (Spec	cify)
Division of Vital	Attending Physician: ar death. ector; After this certification by the funeral director, p	tion: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		b. Time o Injury	f 28c. Inju		28d. Describe			
Divis	al or Attend s after death Il Director; ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ury - At home c. (Specify)	, farm, str	reet, factory, office		28f. Location (City or To		Number or Ru	ral Route Number,
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1 X Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best miner: On the basis o and manner sta	f examination	dge, deat and/or ir	th occurred at the to	ime, date and plac opinion, death occ	ce, and due to the curred at the time,	cause(s) a date and p	and manner as place, and due	s stated. to the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	2			29c. Licen				signed (Monti	
			4000	uyomo			D2330	08		Augus	st 19.	2009
1	541)2		30. Name and address of person who Victor M. Priego,	M.D. 6420	eath (Item 23 Rock 1	Ba) (Type, edae	Print) Dr. Suit	te 4100 F	ethesda.	MD :	20817	
ی	Sta	te.	31. Date filed (Month, Day, Year)									
	Regist		AUG 2 4	2009	and a d	6 1	how V. I					

Registrar
DHMH 17 Rev 1/2001

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Registrar's Signat

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Year)

31. Date filed (Month, Day,

HIGH WAT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death O 8 Month 2009 1430 PM **Physician** SLA CHEBLI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rockville Montgomar ADVENTIST HOSPITAL SHADY GROVE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** MOROCCO 1**⋉**M 2□F Months Days Hours 55 578-37-1220 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show event, the Medical Exactiner cust be indiffed at Rockville 1 XYes 2 ☐ No Director MD 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with I Hygiene. MOROCCO 876 NEW MAYK "natural", or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No <u>م</u> 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Director and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) isor to 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If Item 27 Is marked oth any injuy or other traumatic event ones: Be CHEBLI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rockville MD-20850 876 New Mark Esplande WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 🔀 Removal from State MOROCEO 128/09 4 Donation 5 DOther (Specify) ADEN MUSLIM FUNERAL 21. Signature of Funeral Service Licensee 1242 Ersy Street, Woodbridge VA. Appr imate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) JUNG **Physician** /Medical Due to (or as a consequence of) Examiner BRAIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner or Attending Physician; The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) certificate has been signed by the attending physician rector, page 2 should be detached for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐No 1 □Yes 2 No After this certification, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BANGALORE MD. 9901 MEDICAL CENTER DR. ROCKVILLE MD. 20850

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

			For	State of Mary					giene	-	20523
		1	State Registrar		Ce	rtificate of	Death		Reg. No.	JUJ	
	Physicia		1. Decedent's Name (First, Middle, La.					2. Date of Dea Month	Day	Year	3. Time of Death 2035 P M
1	/Medic	al .		Evelyn E.	Crouse	4b. City, Town, o	or Location of D	August		2009 ty of Death	2035 P ^M
	Examin	er	4a. Facility Name (If not institution, giv 3813 Blue Ball R			E1kto		caur		ci1	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (/	In yrs. last birthday,		If Under 24	Hrs. 8. Date of Birt			place (State or Foreign
	Director		216-20-1227	□M 2 K IF 85	Yrs.	World Days	Hours	April 4	, 1924	Nort	h Carolina
	and w		Usual Residence of Decedent 10a, State 10b, County	10	Dc. City, Town or Lo	ocation				1	0d. Inside City Limits
	Maryla f sho	힏	Maryland Cecil		E1kton						1 □Yes 2 No
	r 28a	Director	10e. Street and Number		Directi	10f. Zip Code			10g. Citizen o	f What Coul	ntry?
	th with		3813 Blue Ball R	oad		21921				ed St	
	ems	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces? 1 ∐Yes 2 🕅 No	er in U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin oan, Mexican, F	? (Specify Yes or No uerto Rican, etc.)	- 14. Ri	ace - Ameri ack, White,	
36	s afte		1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🐼 No If Yes, Give Year or Dates:		1 □Yes 2 🛣 No	Specify:		Spec	ify: Whi	ite
21215-0036	filed within 72 hours after death with the Maryland Hyglene. other than "natural", or items 23a or 28a-f show ent, the Medical Extratrement be rediffed at	Completed by	15. Decedent's E	ducation	16a. Dece	edent's Usual Occu	pation	Lucatina	16b. Kind of		
215	hin 7%	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	e kind of work done DO NOT use retire	ed)			•	ard of
21	ed wit ygien her th	ပ္ပ	12		Ca	afeteria		Name (First, Middle,		cation	
and	be fill ntal H ad oth	Be	17. Father's Name (First, Middle, Last)				erine Neil			
Maryland	12 should be filed within 1 h and Mental Hygiene. 7 Is marked other than " traumatic event, It a Me.	ို	Cary E. Edwards 19a. informant's Name/Relationship	(Type, Print)	19b. Mail	ing Address (Stree		or Rural Route Numb		ın, State, Zi	p Code)
Ma	nd 2 salth ar alth ar 27 ls		Donna C. Harvey/	Daughter	3769	Blue Bal	L1 Road	, Elkton,			
Jre,	of Her		20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 3 ☐	Damaual from State	20b. Place of Disp cemetery, cre Cherry H Methodis	osition (Name of ematory or other pla	ace) Se	ptember	20c. Location		
<u>m</u>	Page ment ant: If ury o		4 □ Donation 5 □ Other (Speci	fy)	Methodis	t Cemete	ry 2,	2009			11, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, fire Medical Examiner must be notified at once.		21. Sign—ure of Funeral Service Lice	2 the ship		22. Name and Add Hicks Hom 103 W. St	ress of Facility ne for I cockton	Tunerals, Street, E	P.A. 1kton.	MD 2	1921
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	pplications that caused the one cause on each line.	e death. Do not e	nter the mode of dy	ying, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between Onset and Death
- de	Physician		Immediate Cause (Final disease or condition		KOIAL						Hours
4	/Medical Examiner		resulting in death)		consequence of):	4 = 61 = 6	A. C. A. I.	. c			MONTHS
		ē	Sequentially list conditions, if any, leading to immediate		consequence of):	N. TANT	13(7)23	14.			7 (0.0 (0,7)
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		NOU A SCI	LLAK P	ISEASE				MONTHS
,092	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Ex	resulting in death) Last	,	consequence of):			6.4			MONTHS
6876	cate b	dical	•	d. METAS	TATLC	ساما	CMC	21			MON (M)
9 x	certifi nding se as	Physician/Medi	IF FEMALE:	23c. If yes, outcome of					23d.	Date of deli	very
Box	death e atter d for u	iciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 4 ☐ Pregnant at ti		☐ Ectopic pregna ☐ Other (specify)				Month	Day Year
P.O.	by the	hys	9 🗆 Unknown	9 🗌 Unknown				ngo Did	tahaana uga a	antributa ta	the cause of death?
	w requires that the death certificate be executed s been signed by the attending physician and ishould be detached for use as the buriat-transit	Completed by F	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause (given in Part I.		Yes 2 1	_	obably 4 ☐ Unknown
SCO		plete						24a. Was	psv		topsy findings available completion of cause of
Ä	The la	l E						perf	ormed? 2 No	death? 1 □ Yes	
/ita	Physician: The law this certificate has al director, page 2 a	Be (25. Was case referred to medical examiner?	Hamilali			Whor:	of Death (Check only			
of	Physician: r this certific ral director,		1 Yes 2 No	28a Date of Injury	t 2 ER/Outpat	ent 3 LI DOA	4 LI Nurs	sing Home 5 Res	how injury oc		cify)
O	The The	tion	1 ■ Natural 5 ■ Pending 2 ■ Accident investigati	(Month, Day,	Year) Injury	/ W	fork? □Yes 2□N	0	• •		
Division of Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification: To	3 Suicide 6 Could not 4 Homicide determine		y - At home, farm, s (Specify)	street, factory, office	е	28f. Location City or To	(Street and Nu wn, State)	ımber or Ru	ıral Route Number,
	pital cours af eral D filled in		29a, Certifier 1 Certifying	Physician: To the best of	my knowledge, de	ath occurred at the	e time, date and	place, and due to th	e cause(s) and	d manner as	stated.
	n 24 hc n 24 hc ne Fun pletely	Medical	(Check only 2 Medical Exone)	aminer: On the basis of and manner state	examination and/or	investigation, in m	y opinion, deat	n occurred at the time	, date and pla	ce, and due	to the cause(s)
_	Vith To th	Σ	29b. Signature and title of certifier				ense number 04771	,	29d. Date sig		1,2009
) Y M					1	74047	,, ,)(
			30. Name and address of person wh			e, Print)	SUITE	#3 ELH	M WOT	ARYL	15P16 OWA
	St	ate	31. Date filed (Month, Day, Year)	S 22. Registrar		A SONE					
	Regist	rar	dent V	146 V	100	1776300	-				

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			For	State of Ma	aryland		partment of I						
	Physici	an	Registrar 1. Decedent's Name (First, Middle				ertificate of	Deam	2.	Date of Dea Month	Day	Year	3. Time of Death
1 1	/Medic Examin	al er	4a. Facility Name (If not institution Kline Hospice 5. Social Security Number	House 6. Sex 7. Ag	e (In yrs. I			Airy	of Death	ugust Date of Birt	th.	2009 County of Death Frederi 9. Birthp Coun	lace (State or Foreign
	Director		125-50-3246 Usual Residence of Decedent 10a. State 10b. County	1⊠ M 2□ F	66	Yrs.		Tiours	Se	ept. 2	22, 1	942 Inc	lia Od. Inside City Limits
	with the Ma 3a or 28a-f s it be rouifie	Il Director	Maryland Fred 10e. Street and Number 5816 Ashburn T	erick	Fı	eder	10f. Zip Code 2170	3			-	en of What Coun	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Mydcal Examiner caust be redified at	by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?		5. 1	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic O an, Mexica		/ Yes or No- an, etc.)	- 1	4. Race - Americ Black, White, e	an Indian,
21215-0036	vithin 72 ho one. han "natur or Medical	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	ct grade completed) College (1-4or t	5+)	(Gi life	cedent's Usual Occu ive kind of work done b. DO NOT use retire	during mo d)	st of working			od of Business/Inc	lustry
Maryland 2	e filed al Hyg sother vent, I	To Be Co	17. Father's Name (First, Middle, Daitari C. Da				incial Ana	18. Moth	ner's Name <i>(F</i>	attana	Maiden S aik	Sumame)	
ore, Mar	1 and Health em 27		Pratap Das/ Ne 20a. Method of Disposition	phew	20b. P	1730	ailing Address (Stree Ol Seneca sposition (Name of rematory or other pla	Chase	Park_	Road	Poo1		, Maryland
Baltimore,	permit. Pages of Department of Important: If Ite any Injury or of Once.		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)		uffer	Cremator 22. Name and Addr	ess of Faci	Augus 16, 20 ^{lity} Staut wn Pike	09 Efer E	uner	erick, M al Homes ck, Mary	
1	Physician /Medical		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)			n. Do not		ing, such a	s cardiac or re	espiratory a	rrest,		Approximate Interval Between Onset and Death Months
,	rate be executed by the hysician and the burial-transit contractions.	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequ	uence of):							
O. Box 6	the death certific y the attending p ched for use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 🗌 Feta	death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су			2	3d. Date of delive	ery Day Year
ords, P	requires that een signed b nould be deta	by	Part II. Other significant condition	ons contributing to death b	out not resu	ulting in the	e underlying cause gi	ven in Part	: I. 		Yes 27	≸No 3□ Prob	ne cause of death?
tal Rec	in: The law ificate has b or, page 2 sh	Completed	25. Was case referred to medical					OC Die	on of Dooth (1 ☐ Yes	psy ormed? 201 No		psy findings available mpletion of cause of
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burn	ation: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	Hospital: 1 Inpati 28a. Date of Inj (Month, Da	ury	ER/Outpa 28b. Tim Injur	e of 28c. Injury	her: 4 🗆 N	280		dence 6	Other (Specif	HOUSE
Divis	pital or Att urs after de eral Directe illed in by t	Certification:	3 Suicide 6 Could determ 4 Homicide 1 Certifyir	in a Zoe, Place Oi III	tc. (Specif	y) 	street, factory, office	time date		City or To	wn, State)		
	To the Hos within 24 ho To the Fun completely	Medical	29b. Signature and title of certifie	Examiner: On the basis and manner s	of examina	ition and/o	r investigation, in my 29c. Licen	opinion, di	eath occurred	at the time,	date and	place, and due to	Day, Year)
7	5		30. Name and address of person Brian O'Conno	r MD 501 Wes	st 7t1	h Str		erick	, Mary	land,	2170)2	,
DH	Sta Regista MH 17 Rev 1/2	ar	31. Date filed (Month, Pay, Year)	2009 32. Regist	rar's Signa	å.	baces						
						OF	IIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Christopher Drazdvs 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 24, 2009 1129 hrs Christopher Valentine Drazdys **Medical Examiner** c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Worcester Rerlin Atlantic General Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Feb 3, 1974 216-78-9589 XM 35 Country) MD Director Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State Ob. County Yes 2 X No MD Carrol1 Eldersburg death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1140 Shortleaf Circle 21784 USA 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White etc Armed Forces Never Married 2 X Married 2 X No white Ves Specify: 1 Yes 2 X No specify: f Yes. Give Year hours after Widowed Divorced If item 27 is marked other than "natural", her traumatic event, the Medical Examiner \$ 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 telecommunications 21215-0036 vice president of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rasa Kudirka Valentinas Drazdys Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Itimore, MD 1140 Shortleaf Circle, Eldersburg, MD 21784 Kelly Drazdys (spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 YBurial 2 Cremation 3 Removal from State 9-3-09 Crest Lawn Memorial Marriottsville, MD Donation 5 Other Specify: 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Page Haight Herbert P.O. Box 195 Sykesville, MD 21784 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Medical Death a. Cardiac arrhythmia Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit AMENDED 23a, PII, 27, perME, g896 10/22/09 TT Physician/Medical X UNPENDED signed by the attending physician be detached for use as the burial-The law requires that the death certificate be Box 68760 23d Date of delivery 23c. If ves, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Month Day Ectopic pregnancy Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 þ Hepatosteatosis Completed certificate has been sector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 ✓ Yes No 26.Place of Death (Check only one) director, 25. Was case referred to medical Be Otherexaminer? Hospital: Nursing Home 5 Residence 6 2 V ER/Outpatient 3 DOA Inpatient this ို 1 V Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 X Natural Yes 2 No Division Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by 3 Could not be Suicide or Town, State) determined To the Funeral (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 25, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD

32. Registrar's Signature

31. Date filed (Month, Day, Year) State AUG 3 Registrar

ORIĞINAL

			State of Maryland 1 - State Registrar	-	rtment of He <i>tificate of D</i>			iene _{eg. No.}	18.0	シャスクく
			Decedent's Name (First, Middle, Last)				2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		JOSEPH J. DICKSON				08-14-	-20Ó9		12:25 P ^M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or L			4c. County		
			Washington Adventist Hospital		Takoma	Park If Under 24 Hrs.	8. Date of Birth		tgome	-
	Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs. las</i> 1 ☐ M 2 ☐ F 97	Yrs.	Months Days	Hours Min.	(Month, Day, 04-12-1	Year)		place (State or Foreign ntry) Bica
	pu 🔉		Usual Residence of Decedent 10a, State 10b. County 10c. City,	Town or Loc	cation					10d. Inside City Limits
	f sho	ō		twood						1∭Yes 2□No
	the h	Directo	10e. Street and Number		10f. Zip Code		1	0g. Citizen of	What Cou	ntry?
	3a ol		3717 Quincy Street		20722			Jamaic	:a	
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - Ameri ck, White,	can Indian, etc.
36	s after	by Fu	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	- 1	□Yes 2X No	Specify:		Specif	^{fy:} Jai	maican
2-00	2 should be filed within 72 hours after death with the Maryland nad Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", are items 23a or 28a-f show raumatic event, the Medical Experience must be recilified at			16a. Deced	lent's Usual Occupat kind of work done du DO NOT use retired)	tion uring most of worki	ng	16b. Kind of B	Business/Ir	ndustry
121	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		ooner			Governm	nent (of Jamaica
Q Z	filed Hygi other ent,		17. Father's Name (First, Middle, Last)			18. Mother's Name			me)	
<u>lan</u>	uld be Menta irked tric ev	To Be	Ephraim Dickson			Elizabe				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Expiritive must be redifficed at once.	8	19a. Informant's Name/Relationship (Type. Print) Eula Dickson/wife	19b. Mailin 3717	g Address <i>(Street ar</i> Quincy St	nd Number or Run reet, Br	al Route Numbe entwood	, City or Town, $Mary1$, State, Zi Land	ip Code) 20722
Baltimore,	les 1 ar of Hea if item or other		t M Duriet 0 □ Commetion 2 □ Bornoval from State	netery, cren	sition (Name of natory or other place)	Date	20c. Location		own, State aryland
Ē	it. Pag rtment rtant; njury o		4 □ Donation 5 □ Other (Specify) Ced 8		.1 Cemeter	<u> </u>	-2009	Sultian	iu, ri	alyland
Ba	Depa Impo any I		21. Signature of Funeral Service Licensee May Hedgman Mo 137	4 Ce	edar Hill	FH, 4111			land,	
П			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.					rest,		Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition resulting in death)	YO CA	ROIAL 1	NFARCT	70N			
1	/Medical Examiner		Due to (or as a conseque	ence of):	FALLUX	0 E				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		1111201					
	acuted nd transit	Examiner	that initiated events C.							
8760,	icate be executed physician and the burlat-transit	a Ex	resulting in death) Last Due to (or as a conseque	ence or):						
687		edical	d							
Box	ending	M/ue	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of		☐ Ectopic pregnancy				ate of del	ivery Day Year
	requires that the death certifit been signed by the attending I nould be detached for use as	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown		Other (specify)					
٩.	that the	Ph	Part II. Other significant conditions contributing to death but not result	ting in the u	nderlying cause give	n in Part I.	23e. Did to	obacco use co	ntribute to	the cause of death?
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000	e law requir has been s e 2 should	Completed	ANEMIA				24a. Was		. Were au	topsy findings available completion of cause of
ž	The law ate has b	Com	STROKE				perfo 1 □Yes	rmed?	death?	2 □No
/ita	Physician: this certific ral director,	Be (25. Was case referred to medical examiner?	,	Othe	26. Place of Dea				
of	Physical direction	<u>٩</u>	Tes 2 No 1 Inpatient 2 E	R/Outpatier 28b. Time o	nt 3 🗆 DOA	4 □ Nursing H	ome 5 Resident			city)
on	nding th. After	tion	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury		? /es 2 □ No				
Division of Vital Records, P.O.	or Atter after dea Director in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	reet, factory, office		28f. Location (, City or To	Street and Nur wn, State)	mber or Ru	ural Route Number,
_	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier (Check only (Check only (Check only) (Check only (Check only) (Check only) (Check only) (Check only) (Check only)	vledge, deat	th occurred at the tim	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and date and place	manner a e, and due	s stated. e to the cause(s)
	thin 2, thin 2, the formplet	Medical	one) and manner stated. 29b. Signature and title of certifier		29c. License	e number		29d. Date sign	ned (Mont	th, Day, Year)
	F 8 F 8		+ JOSRIE		D4	0324		AUGUS.	T 14	,2009
2	2		30. Name and address of person who completed cause of death (Item	23a) (Type,	Print) RROLL AVEN	NE. TAK	coma Pr	HRK. MI	ARH LI	tna 20912
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatu		- 1000)				
	Regist	rar	AUG 2 4 2009 Senera B. Sales	Mark						

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	Otato of Maryla	Ce	rtificate of	Death		Reg. No.	2009	28527
	Physicia	an	1. Decedent's Name (First, Middle, Las WILLIAM E. DICK)					2. Date of Dea	ath Day 26	Year 2009	3. Time of Death * 8:07 P M
	/Medic	al	4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	August		County of Death	0.071
	Examin	er	Upper Chesapeake I		c	Bel A				Harfor	
	Funeral Director		5. Social Security Number 6. S 230–14–5094		s. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da April 7	th y, Year) 7, 19	Cour	place (State or Foreign ntry) t Virginia
	and		Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Lo	ocation				1	10d. Inside City Limits
	Maryl Ff sho	itor	MD Harford	đ	D	arlingtor	ı				1 ☐ Yes 🏖 🗖 No
	ith the	Director	10e. Street and Number	D 3		10f. Zip Code	1034		10g. Citi	zen of What Cour	ntry?
	s 23a	Funeral	1744 Whiteford	12. Was Decedent Ever in	U.S. 13.	Was Decedent of H		pecify Yes or No	-	14. Race - Americ	can Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, I'm Medical Evancium must be rediffed at once.	þ	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cub. 1 ☐ Yes 2 【XNo		o Rican, etc.)		Black, White, Specify: Wh:	ite
7-0-5	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ducation ade completed)	(Give	edent's Usual Occup kind of work done DO NOT use retire	during most of wor	king	16b. Ki	nd of Business/In	dustry
212	filed within Hygiene. other than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Plant Su			Wat	er Plan	t
29 2007 Maryland 21215-0036	ould be filed Mental Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last, Ernest Dickerson					e Keen			
ZE	2 should and Men is marke		19a. Informant's Name/Relationship (Ruth E. Dickerso			ing Address (Street					ip Code) 034
_	1 and Health tem 27		20a. Method of Disposition	205		osition (Name of omatory or other pla		Date		ocation - City or To	
8 26	Pages nent of int: If ii		M☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Contr	Removal from State		iem. Garde	1	/2009	Bel	Air, Ma	ryland
Salti	permit. Departr Importa any inju		21. Signature of Funeral Service Light			22. Name and Addr Iarkins Fi	ess of Facility		D	elta. PA	17314
			23a. Part 1. Enter the disease, or com	polications that caused the de						111	Approximate Interval Between
4	Physician /Medical	2 1	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. No - Due to (or as a cons	TEL	vation 1		15 1 .	far	ction	Onset and Death
7	Examiner	L	Sequentially list conditions,	b. Critical Due to (or as a cons		ic Ste	nosis				
0	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	System	. 0	matory	Cesoon	nsesy	ndr	ome.	
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9116	rtificate bing physic as the bu	dical		d. Possibl	c pn	rumor	110				
ODOO Box 6		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ ∪nknown	23c. If yes, outcome of pre 1 Live birth 2 Fegnant at time 9 Unknown	etal death 3	☐ Ectopic pregnar ☐ Other (specify)	псу			23d. Date of deli Month	ivery Day Year
<u>_</u>	that the ed by detact	Phy	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause g	iven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
\\\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	quires an sign uld be	od by	Pulmonary	edema,	Dem	entia		1 🗆	Yes 2	No 3□ Pr	obably 4 🗌 Unknown
William Nital Becords	The law redate has bee	Completed	['	•				24a. Wa auto per 1 □Yes	opsy formed?	prior to death?	atopsy findings available completion of cause of 2 □ No
β	ian: J	Be	25. Was case referred to medical examiner?					eath (Check only			
	Physician: r this certific ral director,		1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2		ent 3 DOA		Home 5 ☐ Res		6 ☐ Other (Spec	cify)
as	ding After	tion:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Yeal	r) Injury	/ Wo	ork? □Yes 2.□No	250. 5050/150	, 110 tvje	.,, 555555	
ckerson	or Atten after deat Director: in by the	Medical Certification: To	3 Suicide 6 Could not determined	be 280 Place of Injury - A	t home, farm, ecify)	street, factory, office		28f. Location City or To	(Street a	and Number or Ru te)	ural Route Number,
Di	Hospital 24 hours a Funeral I	dical C	29a. Certifier 1X Certifying F (Check only one) 2 Medical Exa	Physician: To the best of my aminer: On the basis of exar and manner stated.	knowledge, de nination and/or	ath occurred at the investigation, in my	time, date and place y opinion, death occ	ce, and due to the	ne cause(e, date ar	s) and manner as	s stated. e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	2 1	1 D	Α.	00680	14		ate signed (Mont	
			30. Name and address of person who	M.D. 500	Uppe	e, Print)	20680 apeake	Dr. B	el-	fir m	27,2009 10 21014
	St Regis	ate trar	31. Date filed (Month, Day, Year) SEP 08	32. Registrar's S	gnature	pares.					

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

an No	ith Douk	1-	For State	Certifi	icate of D			Reg. N	o	60 2012
	Physicia I Examii	n/	. Decedent's Name (First, Middle,Last)				2	Date of Death Month Da August 24, 20	y Year	3. Time of Death U
edica	i Examin		Brian Keith Douka Ha. Facility Name (if not institution, give street			City, Town, or Lo	ocation of Death	, 14.9	4c. County of Death Anne Arundel	
,	:		6023 Ritchie Highway	7. Age (In yrs. last b		Brooklyn If Under 1 Year	If Under 24Hrs.	8. Date of Birth(M		thplace (State or on Pennsylvania
	uneral irector		5. Social Security Number 6. Sex 1 Number 214-88-2394 1 Number 2		Yrs.	Months Days	Hours Min.	August 2	9, 1962 Co	gn Pennsylvania
	any		Usual Residence of Decedent 10a, State 10b, County	10c. City, Tov	wn or Location	1				10d. Inside City Limits 1 Yes 2 X No
•	Maryland 28a-f show any d at once,	į	Maryland Charles	Char	rlotte	Hall 10f. Zip Code		100.	Citizen of What Cou	
;	th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 8326 Roundhill Rd.			20622		US		
	2 should be filed within 72 hours after death with the Maryland hand hygievier hand "matural", or items 23a or 28a-f she 27 is marked other than "natural", or items 23a or 28a-f she imatic event, the Medical Examiner must be notified at once, matic event, the Medical Examiner.		11. Marital Status 12. V	Vas Decedent Ever in U.S.	13. Was	Decedent of Hisp s, specify Cuban,	anic Origin? (Spe Mexican, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - Amer White, etc.	rican Indian, Black,
	er death , or ite r must	Funeral	Never Married 2 Married 1 1 1 2 3 Widowed 4 Divorced If Yes,	Yes 2X No	1	res 2 X No			Specify: W	Thite
	ours aft atural" xamine	d by	15. Decedent's Education (Specify only high	es:	6a, Decedent's	s Usual Occupation	on (Give kind of w		b. Kind of Business	/Industry
36	within 72 h giene. ner than "n Medical E	pleted	Elementary/Secondary (0-12)	ollege (1-4 or 5+)		rant Man			Restaura	int
5-0036	led with Hygiene other t	Comple	17. Father's Name (First, Middle, Last)			1	8.Mother's Name	(First, Middle, Mai	den Surname)	
2121	uld be fil Mental F marked c event, 1	To Be	Peter James Doukas 19a. Informant's Name/Relationship (Type, P	rint)	19b. Mailing	Address (Street	orothy A and Number or R	rbogast tural Route Numbe	r, City or Town, Stat	te, Zip Code)
MD 2	2 shou th and ! 27 is n umafic		Dorothy Doukas/Moth	er	8326 1	Roundhil	1 Rd., C	harlotte	Hall MD	20622
ore, l	permit. Pages 1 and 2 should be filed within 72 Department of Health and Menlal Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical injury or other traumatic event, the Medical		20a Method of Disposition 1 X Burial 2 Cremation 3 Re	20b. Pla cre moval from State			odist Au	gust	Newport,	
Baltimore,	permit. Page Department of Important: injury or other		4 Donation 5 Other Specify: 21 Stanature of Funeral Service Licensee	- Pack		Ceme	tery 2	9.2009 1	chols F.H	
Ва	perm Depa Imp		Christelle 1/1/2.	& MO1403	< B019	95 Three	Notch R	d. Char	lotte Hal	
	nysician Medical		23a. Part I. Enter the disease, or complication failure. List only one cause on each line.	₽.		e mode of dying,	such as cardiac o	r respiratory arrest	, SHOCK, OF HEAR	Between Onset and Death
	caminer			ple Gunshot Wounds o (or as a consequence of):						
		e	Sequentially list conditions, if any, leading to immediate b.	o (or as a consequence of):						
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	cuted ind transit		events resulting in death) Last Due to							
.09	e be exe rsician a burial -	Medical		ENDED					23d. Date of deliv	rery
3876	leath certificate be executed e attending physician and for use as the burial - transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna	2 Fet	tal death 3	Ectopic pregn	ancy	Month	Day Year
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P.O. E	aw requires that the das been signed by the 2 should be detached		Part II. Other significant conditions cont	ributing to death but not res	sulting in the u	inderlying cause	given in Part I.			to the cause of death? Probably 4 Unknown
Is, P	quires then signerally be d	Completed by						24a. Was ar	24b. Were	autopsy findings available to completion of cause of
corc	e law re thas be	mple						autops perform 1 ✔ Yes 2	ned? death	1?
I Re	ian: The certificate ector, page	Be Co	25. Was case referred to medical			26.Place	e of Death (Check	only one)		
Division of Vital Records,	ling Physician: The After this certificate funeral director, page	TO B	examiner? 1 Yes 2 No 27. Manner of Death	Inpatient 2	ER/Outpatient 28b. Time of I		Other Nurs		Residence 6 🗸 O	ther: Scene
o uc	tending Pleath.	ig High	1 Natural 5 Pending	(Month, Day Year) Aug 24, 2009	1825 hrs	· · _ ·	Yes 2 V No	Subject shot	by police	
Visio	or Atte offer des Directo in by the	Certification:	2 Accident Investigation . 3 Suicide 6 Could not be	28e. Place of Injury - At hor		et, factory, office	building, etc.	or Town St		Rural Route Number, City
Ö	ospital hours a uneral I		4 Homicide 29a. Certifier 1 Continue Physician:	(Specify) Parking Lot To the best of my knowledg	ne death occur	rred at the time, o	late and place, ar	d due to the cause	e(s) and manner as	stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. "I the Funeral Director: After this certificate has been signed by the attending physician and for the Funeral Director: After this certificate by 25 should be detached for use as the burial - transi completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) Medical Examiner:On	the basis of examination an manner stated.	nd/or investiga	ition, in my opinio	n, death occurred	at the time, date a	and place, and due t	o the cause(s)
	77	₽	29b Signature and title of certifier			1	se number .M.E.		29d. Date signed August 25, 20	
	TY		30 Mame and address of person who com	oleted cause of death (Item	23a)					
	5		Laron Locke MD. Assistant	Medical Examiner	111 Penr		imore, MD 21	201		
	Regi	State	Allie 2 G EUUS	32 Registrar's Signatu	t. po	Mars				

ORIGINAL

09-06662		Please Type or Print in Black Indelible Ink. Ensure All Copi	
Steven Michael F		State of Maryland / Department of Health and Mental For State Certificate of Death	(1.7) (0) (0) (0)
		Registrar	Reg. No. 2. Date of Death 3. Time of Death
Physicia	,	1. Decedent's Name (First, Middle,Last)	Month Day Year 1549 hrs
Medical Examir	ier	Steven Michael Feeser 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea	
ž.		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea Civista Medical Center La Plata	Charles
		Civista Medical Conto	Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral		Months Days Hours M	Ain. Foreign
Director		224-46-7946 1XM 2 F 35 Yrs. W	Sept. 29,1973 Country Scotland
		Usual Residence of Decedent 10a State 10b, County 10c, City, Town or Location	10d. Inside City Limits
w any		Total State	1 Yes 2 No
and sho	5	VA King George King George 10e Street and Number 10t Zip Code	10g. Citizen of What Country?
Maryland 28a-f show	Director		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		6776 N. Stupet Rd. 22485	U.S. A.
with be ng	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.) 14. Race - American Indian, Black, White, etc.
death nust	إجّ	1 Never Married 2 X Married 1 Yes 2 X No	
after al", c	Đ.	3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify:	Specify: White
ours		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use in the complete of the co	
72 ho	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	
03(atthin one.	ш	2 Logistics ANALY	ist Gov't Contractor
5-0036 led within 72 Hygiene other than		17. Father's Name (First, Middle, Last)	ame (First, Middle, Maiden Surname)
2121 hould be fil nd Mental F is marked utic event,	Be	Tod Michael Feesee Lind	or Rural Route Number, City or Town, State, Zip Code)
21 hould hould is man	ď	Tou, mornante transcriber (1971)	
nore, MD 2 ages 1 and 2 shou nt of Health and N tt: If item 27 is n other traumatic		Cheryl L. Feeser (wife 6776 N. Stuart R	Date 20c. Location - City or Town, State
F. Hear		crematory or other place)	
Pages ent o		4 Donation 5 Other Specify: Cremation Service A	Marsaw, VA.
Baltimore, permit. Pages I ar Department of Her Important: If ite	ПA	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	MARSAW, VA.
in T Deg	13.	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	ac or respiratory arre shock, or heart horizontal proximate Interval Between Onset and
/Medical		failure. List only one cause on each line. Hypertensive atherosclerotic card Immediate Cause (Final disease a.	diovascular disease Death
aminer		or condition resulting in death) Due to (or as a consequence of):	
		Sequentially list conditions, b.	
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
executed ian and ial - transit		d	
e exe	dical	X UNPENDED #23a,27,perME, g896 10.9.09	TT
Box 68760, e death certificate be the attending physic ed for use as the bur	ĕ	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
687 ertific ding p	an/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pre	egnancy Month Day Year
ath co	Sici	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown	
he de hed f	Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	. 23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be as fler death. al Director: After this certificate has been signed by the attending physic led in by the funeral director, page 2 should be detached for use as the burn	þ	Tarkin outer significant containers contained to contain contained to co	1 Yes 2 No 3 Probably 4 V Unknown
S, S, I			24a. Was an 24b. Were autopsy findings available
ord w rec	plet		autopsy prior to completion of cause of death?
leco The la age 2	Completed		1 ✓ Yes 2 No 1 ✓ Yes 2 No
riffic rtiffic tor, p	0	25. Was case referred to medical 26.Place of Death (Ch	neck only one)
Vita ysicia his ce direc	80	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other N	Jursing Home 5 Residence 6 Other:
of Ig Ph]: T	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
OD endir ath. or: ∕	tion	Natural 5 Pending	
risi r Att ter de irect n by	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City or Town, State)
ital o	Certification:	4 Homicide determined (Specify)	or rown, state)
Hosp 24 hou Fune ely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	e, and due to the cause(s) and manner as stated.
Division of Vital To the Hospiral or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, date and place, and due to the cause(s)
70 Wil	Me	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
		o.C.M.E.	OCME August 27, 2009
		30. Name and address of person who completed deads of death (Item 23a)	
Sia		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltin	more, MD 21201
(Y)	tate		
Regis		31. Date filed (Month, Day, Year) AUG 3 1 2009 Serieus 9. Aparks	

		-	For State of Ma		partment of Heal ertificate of Dea				n e	28530
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) ROGER CLI	EVELAND F	INNEYFROCK	M	ite of Death onth gust	Day	Year 09	3. Time of Death 7:00 A M
1	Examin		4a. Facilify Name (If not institution, give street and number)		4b. City, Town, or Local			4c. County	of Death Leric	
*			7504 Lewistown Road 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthda	Thurmon		ite of Birth			place (State or Foreign intry)
П	Funeral Director		217–28–8035 X M 2□ F	78 Yrs.	Months Days Hor	urs Min. May	y 17,	1931	Mar	yland
	D		Usual Residence of Decedent	10c. City, Town or	Leading					10d. Inside City Limits
	show	5	10a. State 10b. County	,						1 □Yes 2 □ No
	28a-f	Director	Maryland Frederick 10e, Street and Number	Thurmon	10f. Zip Code		10	Og. Citizen of V	Vhat Cou	intry?
:	3a or	Ö	7504 Lewistown Road		21788			U.	S.A.	
	be fled within /2 hours after death with the Maryland the Hygiene. do other than "natural", or items 23a or 28a-f show event, Ite I cates Evanian instemmentified at	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S.	3. Was Decedent of Hispani If Yes, specify Cuban, Me	ic Origin? (Specify Y exican, Puerto Rican	es or No- , etc.)		e - Amer k, White,	ican Indian, , etc.
36	s affe	by Fi	1 Never Married 2 Married 1 Yes 2 N	0	1 □Yes 2X□No Spe	ecify:		Specify	· Wł	nite
21215-0036	atural	ted	15. Decedent's Education	16a. De	cedent's Usual Occupation ve kind of work done during	most of working		16b. Kind of Bı		
215	ihin /;	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	life	e. DO NOT use retired)	most of working				
21	lygier her th		9		Farmer	Mother's Name (Firs	t Middle N	Farn		
-	~ = 0 %	Be	17. Father's Name (First, Middle, Last) Calvin Leroy, Finneyfrock			dith Howe			,	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ire	۱۵	19a. Informant's Name/Relationship (Type. Print)		ailing Address (Street and N					
ž	alth a alth a 27 Is er trau		Linda Smith / Daughter	1401	5-A Graceham	Road, Th				
Baltimore,	es 1 a		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dis	sposition (Name of rematory or other place)	Date		20c. Location -	•	
ţ	t. Pag tment tant: ljury o		4 Donation 5 Dother (Specify)	10	el Cemetery	8/20/20				Maryland
Bal	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Similare of Timeral Service Ligensee	150	ROBERT E. DA	N STREET,	THUR	MONT, N	MES, D 21	P.A. 1788
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not	enter the mode of dying, su	ch as cardiac or resp	oiratory arre	est,		Approximate Interval Between Onset and Death
1	hysician		reculting in death)	rdiae ai	rrest					minutes
7	/Medical Examiner		Due to (or as a	a consequence of): the statio	hypotens	100				
		ner	Cognoptially list conditions	a consequence of):	1/					
	ecuted and transii	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a		101				-	
8760,	hcate be executed physician and the burial-transit	a E	Due to (of as a	a consequence of):						
687	ificate g phys as the	edical	d							
Box	Physician: The law requires that the death certificate this certificate has been signed by the attending praid director, page 2 should be detached for use as	by Physician/Me	In the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)				ite of del onth	ivery Day Year
P.0	that the de ned by the a detached t	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death be	ut not resulting in the	e underlying cause given in	Part I.	23e. Did tol	bacco use con	tribute to	the cause of death?
rds,	w requires that s been signed b should be deta	ed by	atrial fibrillation				1 🗆 Ye	es 2∐No	3 2 Pr	robably 4 🗆 Unknown
Division of Vital Records,	The law re ate has be age 2 sho	Completed	pulmonary fibrosis				24a. Was a autops perforr 1 □Yes	sy med?	Were au prior to death?	utopsy findings available completion of cause of 2 □ No
/ita	ctor, p	Be C	25. Was case referred to medical examiner?			Place of Death (Ch	_			
of \	Physic this o al dire		1 Yes 2 No Hospital: 1 ☐ Inpatie	ent 2 ER/Outpa		Nursing Home		ence 6 Ot ow injury occu		cify)
u C	ng ffe	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation				Describe no	ow injury occu	ieu	
)ivisi	or Attending after death. Director: After in by the funer	Certification: To	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury	ury - At home, farm, c. (Specify)	, street, factory, office	28f. L	ocation (Si City or Town	treet and Num n, State)	ber or Ri	ural Route Number,
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical Ce	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner stream.	f examination and/o	leath occurred at the time, or investigation, in my opinion	date and place, and on, death occurred a	due to the o	cause(s) and n date and place	nanner a , and due	s stated. e to the cause(s)
	To the within To the somple	Me	29b. Signature and title of certifier		29c. License nur	mber	2	29d. Date sign		
			M. And Mail	5	MOOZ	5270 -E		8/	18/	09
		1	30. Name and address of person who completed cause of	leath (Item 23a) (Ty	ne Drint\					
	10			rendtsu		17303				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	iale of Mic	ai yiailu /	-	rtificate of	Death	, 0	eg. No.	1 70201
	Physic		1. Decedent's Name (First, Middle, Last)						2. Date of Deat Month		3. Time of Death
	Physici /Medi		Anna Marie George							15, 2009 Year	8:05A M
-	Examir	ner	4a. Facility Name (If not institution, give stree	t and number)			4b. City, Town, or	Location of Death		4c. County of Dea	ath
/			2971 Florence Road				Woodbin			Howard	
и	Funeral		5. Social Security Number 6. Sex	2 🕅 F 7. Age	e (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08/14/1	Year) 9. Bii	rthplace (State or Foreign ountry)
	Director		225-30-7645 Usual Residence of Decedent		84	110.			08/14/1	925 Vi ₁	ginia
	/land		10a. State 10b. County		10c. City, Tow	n or Lo	cation				10d. Inside City Limits
	Man Frsh	ţċ	MD Howard		Woodbi	no					1 □ Yes 2 X No
	n the	Director	10e. Street and Number		woodb1	lile	10f. Zip Code		10	0g. Citizen of What C	ountry?
	h with	a	2971 Florence Road				21797		II.	nited Stat	es
	ems.	Funeral	11. Marital Status	Vas Decedent E	Ever in U.S.	13.	Was Decedent of H	ispanic Origin? (Spe in, Mexican, Puerto		14. Race - Am	erican Indian,
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show other traumatic event, Irs Medical Evanting that has been differed at		1 Never Married 2 Married	☐Yes 2XX N Yes, Give Year or Dates:	lo	1	rres, specify Cuba I⊡Yes 2 XXX No	Specify:	rican, etc.)	Black, Whi	
Baltimore, Maryland 21215-0036	n 72 ho 1 "natur edical I	Completed by	15. Decedent's Educatio (Specify only highest grade con	n mpleted)	16a	. Deced	dent's Usual Occup	ation during most of worki	ng .	16b. Kind of Business	/Industry
12	withi iene. than	mo	Elementary/Secondary (0-12)	College (1-4or 5-	+)			"		۸ ځ ده د د د چ د له	
0	filed Hyg other ent,		17. Father's Name (First, Middle, Last)			ASS	embler	18. Mother's Name		Aircraft Maiden Surname)	
an	ld be lental ked c	To Be	Emmitt G. Rogers					Mary F.		,	
37	2 should be filed wand Mental Hygie is marked other traumatic event, In	-	19a. Informant's Name/Relationship (Type. F	Print)	196	o. Mailin	a Address (Street a			City or Town, State,	Zin Code)
Ž	1 and 2 Health a tem 27 is		Wanda Rollison (dau	abt am)							_,
re	ss 1 ar		20a. Method of Disposition	,	20b. Place o	of Dispos	sition (Name of natory or other plac	Road Woo	ate 2	20c. Location - City or	Town, State
Ĕ	Pages nent of I ant: If ite ary or of		MXBurial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	val from State	1		n Cemeter		/09 1	Frederick,	Maryland
Balt	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee	Bal	1 . /-	22	. Name and Addres	ss of Facility Sta	uffer F	uneral Hom	es P.A.
			23a. Part 1. Enterthe disease, or complication) (Y	telly					rick, MD 2	
			shock, or heart failure. List only one ca	use on each lin	е.				/	1	Approximate Interval Between Onset and Death
Jugadi	Physician /Medical		disease or condition resulting in death)		2001		-4	2 - 9er	1 0	150076	
-	Examiner			Due to (or as a	a consequence	of):					
	1000	e	Sequentially list conditions, b. — b. —	Due to (or es e	consequence	on:					
	rtificate be executed ng physician and as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	an ar rial-tr		resulting in death) Last	Due to (or as a	consequence	of):		1			
68760,	ate be nysici ne bu	Medical	d								
		Med	IF FEMALE:								
Box	ath ce ttendi or use	an/l	23h Was decedent pregnant 230. II	yes, outcome o		3 5	Ectopic pregnancy	,		23d. Date of de	livery
0	Attending Physician: The law requires that the death ce redeath. After this certificate has been signed by the attendicator, the funeral director, page 2 should be detached for use	Physician/	1 Type 2 TNo	☐ Pregnant at ☐ Unknown			Other (specify)			Month	Day Year
ሚ G.	s that ned b	by Pi	Part II. Other significant conditions contribu	ting to death bu	t not resulting in	n the un	derlying cause give	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
ords	w require been sig should b	ed b	Chronic	Qul.	mon	av	4 019	5006 C	1 □ Ye:	s 2□No 3□P	robably 4 Unknown
ပ္ပ	law ri as be 2 shi	Completed							24a. Was an		utopsy findings available
<u> </u>	The ate h	Ö							autopsy perform 1 □ Yes 2	ned? death?	completion of cause of
/ita	cian: ertific	Be (25. Was case referred to medical examiner?					26. Place of Death			
_	Physi this c	၉	1 ☐ Yes 2 No Hospit	1 🔲 Inpatier	nt 2□ER/OL	itpatien	t 3 □ DOA Othe	er: 4 🗆 Nursing Hon	ne 5 🗷 Resider	nce 6 Other (Spe	ecify)
E C	ling f	io iii	1 Natural 5 ☐ Pending	a. Date of Injury (Month, Day)		Time of njury	28c. Injury Work	? _	8d. Describe how	w injury occurred	
<u>s</u>	ttenc death ttor:	icat	2 Accident investigation 3 Suicide 6 Could not be	DI (1)				/es 2□No			
Division of Vital Records,	al or A after I Direc d in by	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	rm, stre	et, factory, office	2	8f. Location (Str. City or Town,	eet and Number or R. State)	ural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		29a. Certifier (Check only one) 29a. Certifying Physician 2 Medical Examiner:	On the basis of	examination an	e, death	occurred at the time	ne, date and place, a pinion, death occurre	and due to the ca	ause(s) and manner a	s stated.
	Fo the within 2 Fo the comple	Medical	one) a	nd manner stat	ed		29c. License			ld. Date signed (Mont	
			Atc. 1	MAT	an	Pol	100	6399	0		
	2	-	30. Name and address of person who comple	ed cause of de	ath (Item 23a)	(Type. F		-///		August 18,	2009
	8						,	4/ 01ney,	Marvlar	nd 20832	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	r's Signature			.,,	141		
	Registra	ar	AUG 2 0 2009	V butters	1. 1	Bau	Car				

State of Maryland / Department of Health and Mental Hygiene

	Registrar 1. Decedent's Name (First, Midd.	le, Last)					2. Date of Deat			3. Time of Death
hysician /Medical		Charlotte	Virginia	Golds	ith		Month August	20 20	Ye ar 2009	2:50a M
xaminer	4a. Facility Name (If not institution	n, give street and nur	mber)		4b. City, Town, o	or Location of Death		4c. Cour	nty of Death	
	Hebrew Home of G	reater Washi				Rockville				gomery
ineral	5. Social Security Number	6. Sex 1 ☐ M 2 🗷 F	7. Age (In yrs. i	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day,		Count	
ctor	232-44-7770 Usual Residence of Decedent		83	110.			June 10,	1926	Mary	yland
	10a. State 10b. County	,	10c. City	y, Town or Lo	cation				10	Od. Inside City Limits
once. To Be Completed by Funeral Director	Maryland Mont	tgomery				01ney				1 ☐ Yes 2 🗷 No
Director	10e. Street and Number	r gomer y			10f. Zip Code	02.10)	1	0g. Citizen o	of What Count	try?
<u></u>	18131 Marksma	an Circle. A	ot. 203			20832			U.S	.A.
Funeral	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13.	Was Decedent of	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No-		Race - America	
F	1 ☐ Never Married 2 ☐ Mar	Armed Fo 1 ☐ Yes If Yes, Giv	2 🔀 No		r Yes, specily Cut 1 □ Yes 2 🔼 No		nican, etc.)		lack, White, e	etc.
d by	3 X Widowed 4 ☐ Divorced	Year or D	ates:		1 1 1 63 2 E 1 1 0	opeany.		Spe	City: C	Caucasian
Completed by	15. Deceder	nt's Education est grade completed)		(Give	dent's Usual Occu kind of work done	during most of work	king	16b. Kind of	Business/Ind	lustry
npl m	Elementary/Secondary (0-12)	College (1	I-4or 5+)	`life. I	DO NOT use retire	,				
S	12				House	ewife	/First Stielelle	Maidan Cum	Domest	:1C
Be	17. Father's Name (First, Middle,	_					ne (First, Middle, i			
은	Ernest Nelson		r.	T			ladys Virgi			0.11
	19a. Informant's Name/Relations				•	t and Number or Ru				
	Tina S. Goldsmit	h - Daughter				Circle, Apt			n - City or To	
	1 ■ Burial 2 □ Cremation	3 Removal from	State State	emetery, crer	sition (Name of natory or other pla	ace)	Date	200. 200410	ii Oily of To	wii, Glato
	4 ☐ Donation 5 ☐ Other (\$		Geor	<u> </u>	ington Cem		4/2009	Adelph	i, Mary	land
ouce	21. Signature of Funeral Service	Licensee	Molo	H ب س	2. Name and Addr ines-Rinal	ess of Facility di Funeral I ampshire Ave	Home, Inc.	or Sori	ng Mary	1and 20904
	23a. Part1. Enter the d. ease, o shock, or heart failure. Lis	r complications that o	aused the deat						iig, nary	Approximate Interval Between
	shock, or heart failure. Lis Immediate Cause (Final	t only one cause on e	each line.	Dan	8 6					Onset and Death
	disease or condition resulting in death)	a. Duo to	(or as a consequ	upped of):	e u n	10 1116	-		_	
1		Due to	(or as a consequ	411	station C	rgal	isms			
ē	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	derice of).	VVV)		1////			
Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S .								
Exa	that initiated events resulting in death) Last	Due to	(or as a conseq	uence of):						
edical		d								
an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregna	ancy I death 3	☐ Ectopic pregnar	ncv			Date of delive	*
içi Çi	in the past 12 months? 1 □ Yes 2 □ No		nant at time of c		Other (specify)	,			Month	Day Year
Physician/M	9 □ Unknown									
by	Part II. Other significant condit	ions contributing to de	eath but not res	ulting in the u	nderlying cause g	iven in Part I.				ne cause of death?
							1 🗆 Y	es 121 No	o 3∐ Prob	ably 4 Unknow
Completed							24a. Was a	an 24	b. Were auto	psy findings availabl mpletion of cause of
E O							perfor	med?	death?	
Be C	25. Was case referred to medica	al			=11	26. Place of Dea	th (Check only or			
To E	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗆	Inpatient 2	ER/Outpatie	nt 3 🗆 DOA O	ther: Nursing H	ome 5 Resid	ence 6 🗆	Other (Specify	y)
	27. Manner of Death	28a. Date	of Injury oth, Day, Year)	28b. Time o Injury	f 28c. Inju		28d. Describe h			
atic	Z LI Accident	igation	, ==,, :=,	,,		□Yes 2□No				
iffic	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be mined 28e. Place	of Injury - At he	ome, farm, str	eet, factory, office		28f. Location (S City or Tow		mber or Rura	I Route Number,
Certification:			J (=F-==				,,	,		
Medical ((Check only 2 Medica	ing Physician: To the	pasis of examina							
ledi	one)		ner stated.		00 1:			00 I D.I!-		Day Vari
-	29b. Signature and title of certific	er /) -		_	nse number		zau. Date sig	gned (Month,	Day, rear)
	Dongle	Jam	wo-		000	10084	l f	tuGU-	ST 20,	2009
	30. Name and address of person	who completed caus	se of death (Item	n 23a) (Type,	Print)	1 50 0	20	2401.0	1.0	200
- 1										
	31. Date filed (Month, Day, Year	PATEL	Registrar's Signa	OIZI	140 N	(ROSE 12)	reter	-1/LUE	M 1 2	0852

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 12:05p M **Physician** 2009 August 18 Sylvia Geller /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Hebrew Home of Greater Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 😿 F New York 89 September 2,1919 Director 112-12-4294 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b, County t be notified at 1 ☐ Yes 2 K No Bethesda Director Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20814 10630 Montrose Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. ed other than "natural", or Iten 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ♣ No Specify Baltimore, Maryland 21215-0036 þ White 3 ☐ Widowed 4 X Divorced Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government **Executive Secretary** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any Injury or other traumatic events. Rose Hocheisser 2 Solomon Geller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 10630 Montrose Avenue, Bethesda, Maryland 20814 Rosel F. Halle - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 08/20/2009 Olney, Maryland 4 □ Donation 5 □ Other (Specify) Judean Memorial Gardens 21. Signature of Funeral Service Licensee MO 102 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death) Advanced Dementia Physician /Medical Due to (or as a consequence of): Examiner ailune 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Daw to (or as a consequence of): Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 21 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 1 Natural

Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. hours after death uneral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8-18-2009 00648 mil 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Montrose Road, Rockville, Maryland 20852 Fazir 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

•	DIVISION OF VITAL DECOMAS, P.O. BOX 00/00,		Daltillore
W	To the Hospital or Attending Physician: The law requires that the death certificate be executed	Ph /I Ex	permit. Pages 1
1	within 24 hours after death.	ys Me	Department of Hi
1	To the Funeral Director: After this certificate has been signed by the attending physician and	sic ed mi	Important: If iten
-	ompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cia ica ine	any injury or oth

		Please	Type or Prin		Indelible Inka epartment of F			-	gible.			
	-	For State Registrar	Otato or Ma	•	Certificate of			Reg. No.	0119	28534		
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Examine		4a. Facility Name (If not institution, gi		4c. County of Death Carrol1								
Funeral				(In yrs. last birtho	Sykesv		8. Date of Bir	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreig Country) NY				
Director	-	117-03-1314 Usual Residence of Decedent	^{1□ M 2}	Yrs	Months Days	Hours Will.	Aug 15	1910		"'/NY		
Maryland a-f show ified at		10a. State 10b. County 10b. Carroll	L	10c. City, Town o					1	0d. Inside City Limits 1 X Yes 2 □ No		
h with the 23a or 28a ist be not	Funeral Director	10e. Street and Number 7200 Third Avenu	ıe		10f. Zip Code 21784			10g. Citizen d USA	of What Cour	ntry?		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and Labould be filed within 72 hours after death with the Maryland Important: If them Z7 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examiner must be notified at once.	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ∐Yes 2 ▼ N If Yes, Give	iver in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Americ Black, White, cify: whi	etc.		
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should and Me s mark umatic	၉	19a. Informant's Name/Relationship			lailing Address (Street	and Number or Ru	ral Route Numb	er, City or Tov		o Code)		
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ages 1 ent of H nt: If ite		20a. Method of Disposition 1 □ Burial 2 【A Cremation 3 I 4 □ Donation 5 □ Other (Spec		cemetery,	crematory or other place nty Cremat:	ce)		Sykes				
permit. P Departm Importar any injur		21. Signature of Funeral Service Lice Page Hough	ensee		22. Name and Addre					Chapel		
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he death or the attenc	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2, □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗆 Fetal death	3 Ectopic pregnand 5 Other (specify)	су		23d.	Date of delive Month	very Day Year		
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The law requires that the death certificate bate has been signed by the attending physic bage 2 should be detached for use as the b	Completed	<i>U</i>					24a. Was auto perfo 1 □Yes		prior to co	opsy findings available ompletion of cause of		
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To the within a comple	Mec	29b. Signature and title of denifier	D		29c. Licens	se number		29d. Date sig				
3		30. Name and address of person wh	o completed cause of d	eath (Item 23a) (Ty	bet Ro	I E Idea	vs burs	MO	2,78	2009 34		
Stat Registra	_	31. Date filed (Month, Day, Year)		ar's Signature	L		0					
riegiati		HUU 41	2009 Jens	un p.	garker							

JOHNNY ELMER 09-06437 ALVEREZ UNKUNK GOMEZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

IX OIN	. 00		- For State	State of	Maryland /		ficate of l					g. No.	20	9	2850
	hysicia	in/	1. Decedent's Name (First, Middle,Last)								Month	ate of Death Ionth Day Year Ugust 17, 2009 3. Time of Death 0514 hrs			
edical	Exami		Johr 4a. Facility Name (if not inst		es Alvar	ez Go	mez	. City, Town, o	r Location o	f Death	August 17	4c. Coun	ty of Deat		
			Washington Adver					Takoma P				Montg	omery		
Fi	uneral		Social Security Number	6. Sex		(In yrs. lasi	t birthday)	If Under 1 Ye			8. Date of Bir	th(MM/DD/YY	YY) 9. Bi Forei	rthplace (S	State or
	rector		None		2F	28	Yrs.	Months Da	ys Hours	Min.	05-07-	1981	C	ountry)Ho	nduras
	ny		Usual Residence of Deceder 10a. State 10b. Co			10c. City, T	own or Locatio	n						1	ide City Limits
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arylar	28a-f show any	윓	10e. Street and Number				Ī	10f. Zip Code			1	0g. Citizen of	What Cou	untry?	
the M	23a or 28a-f show	ă	10330 Royal	Woods (Court			20886				Hondu:			
n with	ms 23 be no	eral Director	11. Marital Status	_	2. Was Decedent Armed Forces?		. 13. Was	Decedent of H	lispanic Orig an, Mexican,	jin? (Spe , Puerto F	cify Yes or No Rican, etc.)	14. Ra	ace - Ame hite, etc.	rican India	in, Black,
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, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland	Hygic d othe		17. Father's Name (First, M								(First, Middle,	Maiden Surna	ime)		
121	fental farke event	o Be	Lorenzo A 19a. Informant's Name/Rela		e Print)		19b. Mailing	Address (Str			Gomez ural Route Nui	mber, City or	Fown, Sta	te, Zip Co	de)
MD 2	and N	۴	Oscar A. Can			•)	I								D 20886
e, ⊼	Health item 2		20a. Method of Disposition			20b. Pl	lace of Disposi rematory or oth	tion (Name of o			Date	20c. Locati			
nor	ages ant of nt: If		1 X Burial 2 Cres 4 Departion 5 Ott		Removal from St	ate	ily Cer			08/2	6/2009	Hond	luras		
Baltimore,	Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		4 Denation 5 Ott		е	^ ~	7 22. N	ame and Addre	ess of Facilit	y W.H	. Bacon	ı Funer	a1 H	ome,	Inc.
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3760	ncate g phys		IF FEMALE: 23b. Was decedent pregna		23c. If yes, outco	me of pregn		tal death	3 Ectop	ic pregna	ncy	23d. Da Mon	te of deliv th	ery Day	Year
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of Vital	ing Phys After thi funeral d	<u>2</u>	1 Yes 2 N 27. Manner of Death	10			28b. Time of I		Injury at Wo	rk?		e how injury o	ccurred		
ono	ending ath or: Al	ţi,	1 Natural 5	1 Natural 5 Pending Aug 17, 2009 0347 hrs 1 Yes 2 ✔ No							Subject stabbed				
Division	or Atte fter de Directe in by t	<u>E</u>	2 Accident 3 Suicide 6	Investigation Could not be	28e Place of I	njury - At ho	ome, farm, stre	et, factory, offic	ce building,		or Town	State			ite Number, City
מֹ בֹ	Hospital or Attending Physician: The law requires that the 24 hours after death. Frameral Director: After this certificate has been signed by the Fameral Director: After this certificate has been signed by the tely filled in by the funeral director, page 2 should be detached.	Certification:	4 V Homicide	determined	(Specify) Pa						5008 Hollyw	ood Road,			
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	To the within 2 To the complet	Medical	29b. Signature and title of		and manner stated				ense numbe			29d. Date			
		2	Zab. Signature and title of	1	1				C.M.E.				17, 20		
			30. Name and address of person who completed cause of death (Item 23a)												
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	(\$	tate				ar's Signatu	ire	,							
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State of Maryland / Department of Health and Mental Hydiene

Eric Ricardo Gran			ate of Mary	land / Dep	artment of	Health a	ind Mei	ntal Hy			201	19 2853
	R	For State egistrar	Un Locati	Ce	ertificate of	Dealii		2	Date of Death	. No.		3. Time of Death
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Weulcai Examine		a. Facility Name (if not institution		n of Death		4c. County	y of Death					
)		2403 Southern Avenu				George's						
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1			8. Date of Birth		Foreign	place (State or
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any	_	10a. State 10b. County		10c. Ci	ty, Town or Locat	ion						1 X Yes 2 No
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or items 23a or 28a-f sho		11. Marital Status		Decedent Ever in Forces?	U.S. 13. Wa	es, specify Co	Hispanic C	origin? (Spe	ecify Yes or No- Rican, etc.)		ace - Americ hite, etc.	an Indian, Black,
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2121 uld be fil Mental F marked	To Be	19a. Informant's Name/Relation			19b. Mailin	g Address (Street and I	Number or R	tural Route Num	ber, City or T	Town, State,	, Zıp Code)
y, MD 2 and 2 shou fealth and N tem 27 is n traumatic		Josephine M		randmo	ther v	1315 N Vashin	lew H	ampsl	nire A	ve.,N	W	
timore, MD : Pages and 2 sh tment of Health an trant: If item 27 i	-	20a. Method of Disposition		20	b. Place of Dispo crematory or o	sition (Name o	of cemetery	. 1	Date 4 / 0 9	20c. Location	on - City or	Town, State
OCE I	-	1 X Burial 2 Cremati		al from State	eritage		rial	,	•	Wal	dorf	, Md
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/Medical	1	failure. List only one cause Immediate Cause (Final disease	se on each line.		e cardi							Death
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760, cate be		IF FEMALE: 23b. Was decedent pregnant in	- Alexa	es, outcome of		etal death	3 E	topic pregna	ancv	23d. Da	te of deliver	Day Year
Box 6876 e death certificate the attending phy ed for use as the l	Physician/M	past 12 months?		ive birth regnant at time o	- C	other (Specif)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,			
Sox death e atter	ysic	1 Yes 2 No 9 1	Unknown 9 U	Inknown		5 (11C) (-)	·					
D. E		Part II. Other significant con	ditions contributi	ng to death but r	not resulting in the	e underlying ca	ause given	in Part I.				the cause of death?
tal Records, P.O. Box 6876 cian: The law requires that the death certificate certificate has been signed by the attending phycefor, page 2 should be detached for use as the	d by											
rds, requir	Completed	-							24a. Was auto	psy	prior to	utopsy findings available completion of cause of
COI e law e has	dm									ormed?	death?	
Re ifficati		25. Was case referred to med	tical			26	Place of D	eath (Check	only one)			
ital sician	Be	examiner?	Hospital:	Inpatient 2	2 ER/Outpatie	ent 3 DO	A Othe	Y4 Nursi	ing Home 5	Residence	6 🗸 Oth	er: Scene
n of Vital Records, ling Physician: The law requir After this certificate has been s' funeral director, page 2 should t	<u>1</u>	1 Yes 2 No 27. Manner of Death	28a.	Date of Injury Month, Day, Year)	28b. Time o	of Injury 28	c. Injury at	Work?	28d. Describe	how injury o	ccurred	
DN C	ion		Pending	Month, Day, Year)			1 Yes	2 No	[
Division al or Attendii rs after death. al Director: A	icat		ould not be 28e.	Place of Injury -	At home, farm, st	reet, factory,	office building	ng, etc.	28f. Location or Town,	(Street and N	Number or F	Rural Route Number, City
Divi	Certification:			ecify)					Of TOWN,	Olato)		
Hos Fun		29a Certifier	g Physician: To th	e best of my kno	wledge, death oc	curred at the t	me, date a	nd place, ar	nd due to the car	use(s) and m	anner as sta	ated.
To the within To the comple	Medical	one) 2 Medical I	g Physician: 10 th Examiner:On the b and man	asis of examinat mer stated.	tion and/or investi				at the time, dat			
F 3 F 8	Me	29b. Signature and title of cer	rtifier	//			License nu					fonth, Day, Year)
		Mllu	Brand	ME)		O.C.M.E	·		Augus	t 24, 200	
		30. Name and address of per	son who completed	cause of death	(Item 23a)		-4 5 10	man a lar	24204			
		Melissa Brassell, M		t Medical Ex		Penn Str	et, Baiti	more, IVIL	2 2 1 2 0 1			
Regis	tate		109 Ren	32. Registrar's	ignatur							

OCME

State Registrar

Box 68760

P.O.

Records.

Vital

Division of

DHMH 17 Rev 1/2001

parke

8186 LARK BROWN RD, SWITE 201 ELKRIDGE, MD 21075

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIBBOUS MD

JOSEAH

31. Date filed (Month, Day, Year) AUG 2 4 2009

State of Maryland / Department of Health and Mental Hygiene Certificate

OI	Г	rea	uu	anu	Mental	rrygiene	
0	f	Dea	ath	1		Reg. No.	l .

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,ai	J	2	0	0	J	~	

Physician
/Medical
Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exeminant must be notified at agree.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	 Decedent's Name (First, Middle, Las 	st)						Month	Day	Year	3. Time of Death
	Alma Hun	ley Hugh	es					August 1	200 با	9	12:28A M
	4a. Facility Name (If not institution, give			1 1		Location of			4c. County		
	24101 Doreen Dr:				iithe	rsbur		8. Date of Birth	Mor	tgom	ery place (State or Foreign
	5. Social Security Number 6. S 579–38–4188	ex 7. Ag □M 2 X F	e (In yrs. last birtl 81		Days	Hours	Min.	(Month, Day,		Coui	hington, D.(
	Usual Residence of Decedent							March 2.	1929	was.	nington, D.
	10a. State 10b. County		10c. City, Town	or Location						1	10d. Inside City Limits
2	Maryland Montgor	nery	Gaith	ersbur	3						1 ☐ Yes 2X No
	10e. Street and Number			10f. Zi	p Code			10	g. Citizen of	What Cour	ntry?
8	24101 Doreen Dr	rive				882			U.S.A		
	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Dece If Yes, spe	dent of Hecify Cuba	ispanic Ori an, Mexicar	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,	can Indian, etc.
֡֝֝֝֝֝֝֝֝֝֝֝֝֝֝֝֓֓֓֝	1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	1 □ Yes 2 □ V If Yes, Give Year or Dates:	NO	1 □ Yes	2 X No	Specify:			Specif	y: Whi	te
2			16a.	l Decedent's Usi	ual Occup	ation		T.	 6b. Kind of B		
2	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)	de completed) College (1-4or 5		(Give kind of w life. DO NOT t	ork done o ise retired	during mos i)	t of worki	ng			
5	12	College (1-401 c	H	lomemake	er				Own H	Iome	
١	17. Father's Name (First, Middle, Last))				18. Mothe	er's Name	(First, Middle, N	faiden Surnan	ne)	
2	William Henry	y Hunley,						Gertru			
	19a. Informant's Name/Relationship (*		•	•						o Code) 20882
	Kathleen M. Hugh	nes – Daug							Coc. Location		Maryland
	1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		Disposition (Na v, crematory or						•	Virginia
	4 □ Donation 5 □ Other (Specifical Signature of Fulleral Service Licer		necrop	22. Name a				7 = 7, 0 5 1			1118
	hourt L.	Willia	ms					P.A., 1			
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death. Do n	ot enter the mo	de of dy	g, such as	cardiac	or respiratory arre	est,	Lanu	illierval between
	Immediate Cause (Final disease or condition	. Ven	ri Cn	Var 1	Avr	yth	m i	a			Onset and Death
	resulting in death)	Due to (or as	a consequence o	f):		,		Kwos			
5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to lor as	a consequence o		MCC	Y_	WY.	PVVVV	1	_	
	Cause (Disease or injury	540 10 101 43	a comocquomos c	.,.							
LYG	that initiated events resulting in death) Last	C. Due to (or as	a consequence o	f):							
enical	•	d									
ב ע	TE ESTATE										
2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Fetal death	3 ☐ Ectopic	pregnanc	٧				ate of deliv	
200	in the past 12 months?	4 ☐ Pregnant a 9 ☐ Unknown		5 Other (s					IVI	Ontin	Day Year
Ę	9 ☐ Unknown Part II. Other significant conditions of	contributing to death h	ut not resulting in	the underlying	cause div	en in Part I		23e. Did tob	acco use con	tribute to t	the cause of death?
2	Tat II. Other signmount contains to	on the date of the	a		ouaso g				s 2 No		bably 4 🗆 Unknown
biered								24a. Was a	246	More aut	oney findings available
5		·						autops perform	ned?	prior to co	opsy findings available ompletion of cause of
3	25. Was case referred to medical	1				OF Blood	of Dooth	1 ☐ Yes 2	No No	1 ☐ Yes	2 No
ă	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital:	ent 2 ER/Out	tnatient 3□ [OA Oth	er:		me 5 X Reside		her (Sneci	ify)
	27. Manner of Death	28a. Date of Inju		ime of	28c. Injui Wor			28d. Describe ho			
9	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	n	y, rear) "	M	1 🗆	Yes 2	No				
ermicano	3 ☐ Suicide 6 ☐ Could not be determined	e 28e. Place of Inj building, et	ury - At home, far c. <i>(Specify)</i>	m, street, facto	ry, office			28f. Location (St City or Town		ber or Rur	ral Route Number,
)	A CONTRACT OF THE PARTY OF THE	T-11	-f lus l d a	d - akb	-1 -4 AL - A						-total
calcal		hysician: To the best miner: On the basis of and manner st	f examination an								
K	29b. Signature and title of certifier		1. 0			e number			9d. Date signe		
	53	2/	NI		20	062	43	5	August	15,	2009
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAYED ELSAYYAD 10110 Molecular D. Rockville, MD 20856										

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 17

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			State of Maryland / Department of Health and M 1 - State Registrar Certificate of Death		liene eg. No. 🤌 🧻	119	2953
	Dharisi		1. Decedent's Name (First, Middle, Last)	2. Date of Deat Month		3. Tim	ne of Death
	Physicia /Medic		Margaret S. Hodgdon	August			:36a ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of		
p. P.			Dove House Westminister 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Car		ate or Foreign
П	Funeral Director		220-12-0037 1□ M 2対 F 84 Yrs. Months Days Hours Min.	(Month, Day, April 1:		Birthplace (St. Country)	alo or r oreign
	ס		Usual Residence of Decedent	Whiti I	J 1 J 2 J		
	arylar show	_	10a. State 10b. County 10c. City, Town or Location				de City Limits Yes 2 ☐ No
	ne Ma 18a-f	Directo	Maryland Carroll Mt. Airy				Tes Z INO
	with t		10e. Street and Number 10f. Zip Code	1	0g. Citizen of Wha	,	
	ns 23	Funeral	1007 Parade Lane 21771 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-		States American India	
36	be fled within 72 hours after death with the Maryland arthygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Evenine must be notified at	by Fur	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ No Specify: 1 □ Yes 2 ☒ No Specify:	Rican, etc.)		White, etc. White	
5-0036	2 hou atura		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Busin		
215	thin 7 te.	Completed	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired) (Give kind of work done during most of work life. DO NOT use retired)	ing			
21	filed with Hygiene. ther than		12 Homemaker		Own H	lome	
and		Be	17. Father's Name (First, Middle, Last) 18. Mother's Name C. Al. 1	,	Maiden Surname)		
2	id 2 should be Ith and Mental 27 is marked c rraumatic eve	으	Unknown Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Run		r City or Town St	ato Zin Codo)	
Ž	id 2 s Ith an 27 is r trau	0.3	Scott Hodgdon / Son 4840 Ridge Road, Mt. A				
Ē,	ss 1 and 2 of Health item 27 is r other tra	3	20a. Method of Disposition 20b. Place of Disposition (Name of		20c. Location - Ci		e
E E	Pages nent of int: If its iry or o	3	1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Stauffer Crematory Inc. 8/1	8/2009	Frederi	ok Mar	v1and
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature Funeral Service Licensee 22. Name and Address of Facility				
m —	89 = 89	G 71	Stauffer Funeral Ho 1621 Opossumtown Pi	mes P. A ke, Fred	lerick, M	laryland	1 21702
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arm	est,	Approx Interva	imate I Between and Death
Ly.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. ASDITUTE DIPUTED TO THE DIPU	nia		ca	45
-	Examiner		Due to (or as a const quence of):			(An	6
		er	Sequentially list conditions, if any, leading to infinediate b.			- 101	->
	cuted Id ansit	Examiner	If any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events c.				
Ó,	e exe ian ar ıriaî-tı	EX	resulting in death) Last				
98760	rificate be executed g physician and is the burial-transit	edical	d				
		/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		001 0.11		
Вох	iaw requires that the death cerl as been signed by the attendin 2 should be detached for use s	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 1 Clive birth 2 Fetal death 1 Clive birth 2 Fetal death		23d. Date of Month		Year
0	the d	nysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown				
رن ح.	w requires that the do been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	bacco use contrib	ute to the cause	of death?
ğ	equire en siç ould b			1 □ Y€	es 2□No 3	☐ Probably 4	Unknown
ecc	as be 2 sho	ompleted		24a. Was a		re autopsy findi or to completion	
<u> </u>	cate ha	Com		perforr	med2 dea	ith? ¶Yes 2 ∐nNo	
Vital Records,	Physician; The lav this certificate has al director, page 2	Be	25. Was case referred to medical examiner?	h (Check only on	ne)	-73	
0	Phys this aldir	٦.			ence 6 GOther	(Specify)	ISpice
<u>.</u>	ding h. After fune	tion	1 Natural 5 Pending (Month, Day, Year) Injury Work?	260. Describe no	ow injury occurred		
Division	Atten r deat ctor: by the	fica	3 Suicide 6 Coulombia de 28e. Place of Injury - At home, farm, street, factory office		treet and Number	or Rural Route	Number,
<u> </u>	al or s after il Dire	Certification:	4 ☐ Homicide determined building, etc. '(Specify)	City or Town	n, State)		
:	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, t	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, and 2 Medical Examiner: On the basis of examination and 2 Medical Examiner: On the basis of examination and 3 Medical Examiner: On the basis of examination and 3 Medical Examiner: On the basis of examination and 3 Medical Examiner: On the basis of examination and 3 Medical Examiner: On the basis of examination and 3 Medical Examiner: On the basis of examination and 3 Medical Examiner: On the basis of examination and 3 Medical Examiner: On the basis of examination and 3 Medical Examiner: On the basis of examination and 3 Medical Examiner: On the basis of examination and 3 Medical Examiner: On the basis of examination and 3 Medical Examiner: On the basis of examiner: On the basi	and due to the c red at the time, d	cause(s) and mani late and place, an	ner as stated. If due to the cau	ıse(s)
:	Vithin To the comp	Me	29b. Signature and the of certifier 29c. License number	2	9d. Date signed (Month, Day, Ye	ar)
			INELIN Joel Kordin WI) DOGS &	8	August 1	7, 2009)
	15		30. Name and address of person who completed cause of death (Item 23a) (Type, Frint)				
			Melvin J. Kordon MD 9501 Old Annapolis Road, Ellicott 31. Date filed (Month, Day, Year) 32, Registrar's Signature	City, Ma	ryland 2	1042	
	Sta Begistr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August **1**岁 2009 **Physician** 10:28pm Vincent L. HansBerry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Montgomery Potomac Manor Care Potomac 9. Birthplace (State or Foreign District of Columbia 8. Date of Birth (Month, Day, Year) 09-19-1930 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Hours 1 x M 2 ☐ F 78 578-36-5560 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Oppertment of Health and Mental Hyglen's propertment of Health and Mental Hyglen's returner. The marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the "Assign Examinar must be restitived at √ Yes 2 No Director DC Washington 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 20715 409 Missouri Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 21€ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specialack \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Auto Electric Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Lee ပ Harry L. Hansberry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4617 Langston dr Bowie MD 20715 Laura Hansberry Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 8/25/2009 Clinton, MD Ressurection 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
W. Wesley Chavis III Funeral Service INC
10684 Southern MD BLVD Dunkirk, MD 20754 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Parostate cancer **Physician** tesstatic 1210 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Dlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ⊠No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 001 D0054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunitho Bhogavillimo, 9801 Geongia Arma #1-17, Silverspring 32. Registrar's Signature 31. Date filed (Month, Day, State AUG 2 4 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0030 A^M 2009 Rev. Robert Joseph Hermley, O.S.F.S. August 30 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Ceci1 Annecy Hall Childs Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday, 5. Social Security Number 6. Sex 1 M M 2 □ F **Funeral** Days Months Hours SEPT 26, 1927 Pennsylvania Director 81 204-20-0302 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expringer must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 X No Director Childs Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21916 1120 Blue Ball Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No 11. Marital Status 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 💢 No Baltimore, Maryland 21215-0036 Specify: Specify. þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Priest Religious 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Notlev Thomas Hermley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2200 Kentmere Parkway, Wilmington, DE Oblates of St. Francis de Sales 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2, 2009 Childs, MD 4 ☐ Donation 5 ☐ Other (Specify) Oblate Cemetery 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21921 103 W. Stockton Street, Elkton 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** crebin disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if the sequentially list conditions, if the sequential seq Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) been signed by the should be detached 1 □Yes 2 □ No. 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ils certificate has director, page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of Injury 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier -0005526 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E Horal 412 Suburban Plaza, Newark, DE 32. Registrat's Signature 31. Date filed (Month, Day, Year) State 08 SEP Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0909 Aug. 13, 2009 Elizabeth Toyin Ijelu /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Shady Grove Adventist Rockville Montgomery 8. Date of Birth (Month, Day, May 8 f Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1982 Days Hours Min. 1 □ M 2 🔀 F Maryland 216-53-0598 27 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Walfall Eval. For most be notified at 1 □Yes Ž No MD Montgomery Gaithersburg Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20879 9118 Bobwhite Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛣 No Specify: \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecilia Caetano Ijelu Jackson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. 9118 Bobwhite Circle Gaithersburg, Md. 20879 Jackson Ijelu/Father Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1

☐ Burial 2 ☐ Cremation 3 Removal from State 8/20/2009 Silver Spring, Md. Gate of Heaven □Other (Specify) 4 Donation PHILIPAD: RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final minutes Physician Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** years Multiple Sclerosis Sequentially list conditions, it may be in all immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed and the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical use as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) the detached 9 I Inknown cate has been signed by tage 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 X No 1 ☐Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Hospital: 1∐ Yes 2.2**X**No 1 Inpatient 2 NER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 X Natural 5 Pending 1 ∐Yes 2 ∐No death. investigation 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the t 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar

31. Date filed (Month, Day, Year)

Name and address of person who completed William Dooley

AUG 21

2009

M.D. 901 Medical Center Drive Rockville, Md 20850 32. Registrar's Signature

	1	For State Registrar	tate of Maryland /		rtment of He tificate of D		Re	g. No. 🤰	1110	2854
Physicia /Medic	_	1. Decedent's Name (First, Middle, Last) Richar	d K. Jordan				2. Date of Death	20 2	0ŎĠſ	3. Time of Death 7:00 P M
Examin		4a. Facility Name (If not institution, give stree 8518 Wind Dance Way			4b. City, Town, or I	ia		4c. County of Death Howard		
Funeral Director		5. Social Security Number 6. Sex 182–12–4008	2□ F 7. Age (In yrs. last b	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 4/25/19	21 (21)	9. Birth	place (State or Foreigr ntry) PA
Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Howard	10c. City, To		ation					10d. Inside City Limits 1 ☐ Yes 2 💆 No
with the	al Director	10e. Street and Number 8518 Wind Dance Way			10f. Zip Code 21045		10	og. Citizen of USA	What Cou	ntry?
s after deat ", or items?"	by Funeral	1 ☐ Never Married 2 🙀 Married	Was Decedent Ever in U.S. Armed Forces? 1X∑Yes 2 □ No If Yes, Give 1943- Year or Dates:	- I	Vas Decedent of His Yes, specify Cubar □Yes 2⊠No	Specify:	ecify Yes or No- Rican, etc.)		ice - Ameri ack, White, ify: Wh	
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exprance must be notified at	Completed k	15. Decedent's Educati (Specify only highest grade co	1952 ₆	`life. D	ent's Usual Occupa kind of work done do OO NOT use retired)	ation uring most of work	ing	16b. Kind of E		ndustry
d be filed wi ental Hygier ced other th c event, Inc	Be	17. Father's Name (First, Middle, Last) Thomas A. Jordan	2	Mac	hinist	18. Mother's Name				
ind 2 shoul alth and Mi 27 is marl er traumati	2	19a. Informant's Name/Relationship (Type. Terri J. Kindrock/Da		9b. Mailin .1803	g Address (Street a Bignonia	and Number or Rur	urel, MD	20708	3 	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State Arder	nt Cr	sition (Name of natory or other place remation S	Svc 8-21	-2009	Hanove	er, M	D
permit. Depart Import any Inj		21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complicate	thy M01044	41	.12 Old Co	olumbia F	ike Elli	icott (City,	ily FH Inc MD 21043
requires that the death certificate be executed Washington by the attending physician and anould be detached for use as the burial-transit anould be detached for use as the burial-transit.	dical Examiner	shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	e of):	no lic Ca mo Di	sease	alar	/) (rul	Onset and Death
he death certific / the attending p ched for use as i	Physician/Med	IF FEMALE: 23c 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3	Ectopic pregnancy Other (specify)	У			Date of deli Month	very Day Year
quires that the de an signed by the uld be detached	by	Part II. Other significant conditions contri	outing to death but not resulting	g in the u	nderlying cause give	en in Part I.	23e. Did to			the cause of death?
The law ate has b page 2 sl	Completed							med? 2 ½ No	prior to death?	topsy findings availa completion of cause of
ath. T. After this re funeral dir	Certification: To Be	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Year) 28 28e. Place of Injury - At home	b. Time o Injury	M 1 🗆	er: 4 □ Nursing H	28d. Describe h	ence 6 XX ow injury occ	urred	cify) Asst. Li
To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the		4 Homicide	building, etc. (Specify) ian: To the best of my knowler: On the basis of examination	dge deat	h occurred at the ti	me, date and place	City or Tow	cause(s) and	manner as	s stated.
To the Hi within 24 To the Ft complete	Medical	one) 29b. Signature and title of certifier	and manner stated.		20c Licens	e number		29d. Date sig	ned (Monti	h. Dav. Year)
H)~		30. Name and address of person who com	oleted cause of death (Item 23	Ba) (Type,	Print)	10 Rus	3, 0,00	Augus	t 21,	2009 Baltinure mayer 21
Sta Regist		31. Date filed (Month, Day, Year) AUG 2 4 2009	32. Registrar's Signature	-10	1 1 1		4 ,4 (6		<u> </u>	Mayer 2

DHMH 17 Rev 1/2001

		1	For State Registrar	Otato of	Waryland		rtment of H tificate of L			Reg. No.	2000	28544
	Physicia		1. Decedent's Name (First, Middle						2. Date of De Month August		2009 ^{Year}	3. Time of Death 10:10 AM
	/Medic	al -	David Mercer 4a. Facility Name (If not institution	Kiefer	nher)		4h City Town, or	Location of Death			County of Death	10:10 11
	Examin	er i	1933 Poplar Vie				Sandy Sp			Montgomery		
J	Funeral Director		201-14-3612	6. Sex 1 M M 2 □ F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Mar 18	th ay, Ye <i>ar</i>) 192	9. Birthp Coul Penns	place (State or Foreign htry) ylvania
bachac	show	. [Usual Residence of Decedent 10a. State 10b. County			Town or Loc					1	1 ☐ Yes 2 ☐ No
AN OH	28a-f	rect	MD Montgo	mery	Sandy	Spri	10f. Zip Code			10g. Citiz	en of What Cour	
district	3a or	<u>E</u>	1933 Poplar Vie	w Lane			20860			USA		
5-0036	permit. Pages I and 2 should be lifed whitin 7.2 flodus ariet beath with the year year. I mortament of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Dece Armed For 1 X Yes	dent Ever in U.S. ces? 2 No e ates: 1944-4	1	Vas Decedent of H fYes, specify Cuba □Yes 2XNo	ispanic Origin? (S _I n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Ameri Black, White, Specify: Whi	etc.
00-61	"natural	Completed t	15. Decedent (Specify only highes	's Education t grade completed)		16a. Deced	lent's Usual Occup kind of work done o	during most of worl	king	16b. Kin	d of Business/In	dustry
7	iene.	dwo	Elementary/Secondary (0-12)	College (1- 5+	-4or 5+)	ditor						Organizat
מוומ	ntal Hyg ed other event,	Be	17. Father's Name (First, Middle, John Michael Ki					18. Mother's Nam Mary Bro			Surname)	
Maryland ZIZI3-0036	th and Me	ပ	19a. Informant's Name/Relationsl Katherine Kiefe		r		ng Address (Street Chard Te					p Code)
Банттоге,	ages I an ent of Heal nt: If Item 2 y or other		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S)		Cet	metery cren	sition (Name of natory or other place rney Crei	matory 08	Date 3/22/09	l	cation - City or To	
Dali	Departm Departm Importar any Injur once.	Ì	21. Signatur of Funeral Sovice Licensee Coiling and Address Cremitation Service P.O. Box 784 P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 2								× 784	
E	hysician and business and business and business the prival-transit	edical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Sarco Due to (ence of):						Onset and Death 6 months
7	deain cerni e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live t	come of pregnan birth 2□ Fetal nant at time of de own	death 3[☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	y		2	23d. Date of deli Month	very Day Year
US, T.	es .Eree	ρ	Part II. Other significant condition	ons contributing to de	eath but not resul	ting in the u	nderlying cause giv	en in Part I.			. 7	the cause of death?
	ate h page	Completed							per 1 □ Yes	opsy formed? 2 XNo	l death?	topsy findings available completion of cause of 2 □ No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Pnystctan: The rate care this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:		-0.0	Ott	26. Place of De			6 ☐ Other (Spec	-if-i
5 i		tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date (Mon	Inpatient 2 E of Injury th, Day, Year)	28b. Time o Injury	of 28c. Inju	4 Li Nursing r	28d. Describe			ary)
DIVISION	I or Attending after death. Director: Afte I in by the fune	Certification:	3 Suicide 6 Could 4 Homicide detern	not be 28e, Place	of Injury - At hor ing, etc. (Specify	ne, farm, st	reet, factory, office		28f. Location City or T	(Street and	d Number or Ru)	ıral Route Number,
:	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by the	Medical C										
	^	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 20, 2009									
(XX		30. Name and address of person				Print) Street Su	ite 300 i	Keneina	ton	MD 2080	5
	- 0		Manish Agrawal	4 2009 32.	egistrar's Signat	Urea C	, creer bu	TCC 200 I	CIBILIA		. 2003 س	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2009 **Physician** 22:40 August 16 DOUGHERTY KUKAR CONSTANCE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Olney Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F Pennsylvania 228-52-9846 72 Dec. 26 1936 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 No Laytonsville Director Md. Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20882 United States 8001 Seneca View Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify: Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien. Important: If item 27 is marked other tha any injury or other traumatic... Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Menewisch Α. Helene Dougherty Charles 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8750 Ravenglass Way, Gaithersburg, Md. 20886 19a. Informant's Name/Relationship (Type. Print) 8750 Ravenglass Way, Bruce A. Crum / Son 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Alexandria, Virginia 8/18/09 Metropolitan Crem. 5 ☐ Other (Specify) 4 □ Donation 22. Name and Address of Facility 21. Sign tury of Funeral S Lice Muriel H. Barber Funeral Home Md. 20882 00970 Box 5038, Laytonsville, P. O. 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 XNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Medical Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 🔀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-traf Division of Vital Records, P.O. Box 68760, physician attending ph ed by the a cate has been signed by page 2 should be detach certificate funeral director, this After t death. within 24 hours after death

To the Funeral Director:
completely filled in by the

28a-f show

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23a

or items

"natural",

72 hours after

be filed within 7 ental Hygiene. than

Baltimore, Maryland 21215-0036

traumatic event, the Medical Examinar roust be natified at

20

Registrar

Aruna Paspula, M.D. 31. Date filed (Month, Day, Year) State

4 Homicide

29a. Certifier (Check only one)

29b. Signature and title of certifier ulina

MD

29c. License number

60999

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 0

20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18101 Prince Philip Drive, Olney, Md.

Registrar's Signature

AUG

Be Completed by Funeral Director

ဂ္

Examiner

Medical Certification: To Be Completed by Physician/Medical

Physician

/Medical

Examiner

Funeral

Director

For State		State C	n maryi	and / De	-	ificate					61	12.15	13 100 100 2
Registrar					eri	псан	OIL	Jean			g. No.	11115	2854
. Decedent's Nam	,									2. Date of Death Month		th Year	3. Time of Death
Robert										AV6UST	19	2009	0010
		n, give street and nu	ımber)			4b. City, T					4c. Cou	nty of Death	200
Season Social Security N		i.ce 6. Sex	7 Ago //p	yrs. last birtho	10.0	Ra If Under 1		11sto		8. Date of Birth		Baltir	liore place (State or Foreig
212-32-6		1 M 2 □ F		72 Yr			Days	Hours	Min.	(Month, Day, Nov 21	Year)	Coul	ntry) MD
sual Residence of		4.5		4						1100 21	1930		
a. State	10b. County		10c	. City, Town o	r Loca	ation						1	10d. Inside City Limits
MD	Caı	rroll		Westn	iins	ster							1 ☐ Yes 2 📆 No
e. Street and Nu	mber					10f. Zip (Code			10	g. Citizen	of What Cou	ntry?
2305 Lee	ward D	rive					21	158			τ	JSA	
. Marital Status	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	12. Was Dec	edent Ever i	n U.S.	13. W	as Decede	ent of H	ispanic O	rigin? (Sp	ecify Yes or No- Rican, etc.)	14. 1	Race - Ameri	can Indian,
1 Never Marr	ied 2 🔀 Marı	Armed For	orces? 2 ☐ No							Hican, etc.)		Black, White,	etc.
3 Widowed		If Yes. G	ive Dates:		1[Yes 2	⊠ No	Specify	:		Spe	ecify: W	nite
/0	15. Deceden	t's Education				nt's Usual					6b. Kind o	f Business/In	dustry
(Special Special Speci		st grade completed) College (- (%	ive ki fe. D0	nd of work O NOT use	aone d retired	iuring mo: ')	sı ot worki	ing			
12	, (0 .2)				(Clerk					B &	0 Rai	lroad
'. Father's Name	(First, Middle,	Last)						18. Moth	er's Name	e (First, Middle, N	laiden Suri	name)	
Ralph P	eyton 1	Keffer, S	r					V	irgie	Lee Pie	erce		
a. Informant's N	ame/Relations	hip (Type. Print)		19b. N	failing	Address	Street	and Numb	er or Rur	al Route Number,	City or To	wn, State, Zij	o Code)
Aurora K	effer/	wife		23	305	Leew	ard	Driv	re W	<i>l</i> estminst	er, N	D 21	158
a. Method of Dis	,		20	b. Place of D	isposi	tion (Nam	e of ner plac	e) (08/21	72009	20c. Location	on - City or To	own, State
1X Burial 2 4 ☐ Donation		3 ☐ Removal from Specify)	Siale	crestla					•		Marr:	iottsv:	ille, MD
I. Signature of Fu				J. O. O. O.						ne and Ch			•
)	11	1-				12 Wa							21157
	ırt failure. List (Final	complications that only one cause on a a	each line.	death. Do not	enter	107.0					est,		Approximate Interval Between Onset and Death
equentially list co	nditions,	b. =											
equentially list co any, leading to im ause (Disease or	mediaté	Due to	(or as a cor	sequence of)	:							12.5	
ause (Disease or at initiated events sulting in death) l	3	C	/or oc 2 2==	A 22220000									
g wowii)		Due to	(Or as a cor	sequence of)									
		d											
FEMALE: 3b. Was deceden in the past 12 1 Yes 2 [9 Unknown	months? ⊒No		birth 2 🗍 gnant at time	Fetal death		Ectopic pr Other <i>(sp</i> e		/			23d.	Date of deliv Month	ery Day Year
art II. Other signi	ficant condition	ons contributing to a	leath but not	resulting in th	ne und	lerlying ca	use give	en in Part	l.	23e. Did tob	acco use o	contribute to t	he cause of death?
3		3 1				, , ,	3			1 □ Ve	s 2 🗆 N	o 3□ Pro	babiy 4 Unknowi
			-										
										24a. Was ar autops perforn 1 □ Yes 2	y	4b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of 212 No
5. Was case refer examiner?	red to medical							26. Plac	e of Deat	h (Check only one	9)	STEADOR	4
1 Yes 2 K	No	Hospital: 1	Inpatient	2 🗌 ER/Outp	atient			4 🗆 N	ursing Ho	me 5 🗆 Reside	nce 6 🖺	Other (Speci	s it uspice
7. Manner of Deat 1° Natural 2 Accident	h 5 ☐ Pendin investi	19	of Injury oth, Day, Yea	28b. Tin Inju		M 28	3c. Injur Worl 1 □	yat ⟨? Yes 2 [.	28d. Describe ho	w injury oc	curred	

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit

Physician

/Medical

		1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 No 1 □ Yes 2 No
25. Was case referred to medical	26. Place of Death ((Check only one)
examiner? 1 ☐ Yes 2 【No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home	e 5 Residence 6 Other (Specify)
27. Manner of Death 1* Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year) Injury Work?	d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		if. Location (Street and Number or Rural Route Number, City or Town, State)
	nysician: To the best of my knowledge, death occurred at the time, date and place, an miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 9.2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5400 OLD COURT Road Randallstown MD 32. Regetrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

WJL 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death gust 16. Physician/ 2009 3:25 P М Nancy Bess Lawrence Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days June 19. North Carolina 1 □ M 2 🔀 F Months Hours 1924 85 220-18-7703 Director Usual Residence of Decedent show 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. em 27 is marked other than "natural", or items 23a or 28a-1 show 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 X Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2915 Westwood Ave. 21216-3526 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces' Black White etc. ģ 1 Never Married 2 Married 1 lx Yes 2 If Yes, Give 2 No Specify:African American Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of health and Mental Hyglene. Important If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Alice Lanier Mack Bess 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alvania Slade/ Sister 21216-3526 2915 Westwood Ave. Baltimore, M<u>aryland</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition August 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 24, 2009 Suitland, Maryland ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial 22. Name and Address of Facility Stewart Funeral Home, 21. Sign ture of Furneral Service Licentine 4001 Benning Rd. NE Washington, DC 20019 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Immediate Cause (Final Physician/ nlications disease or condition resulting in death) OM Medical Due to (or a a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 1 ☐ Yes 2 ½ 9 ☐ Unknown q 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, 26. Place of Death (Check only one) Be Hospital: 2 No Hospice ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the within 2 To the F 3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

cr 2

State Registrar Date filed (Month, Day, Year)

32. Registrar's Signature

Hora

201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

charles

R149194

St. Balkinon MD

2000

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Evaninar must be rediffied at once.

Baltimore, Maryland 21215-0036

/Medical

physician and s the burial-trans ours after death.

eral Director: After this certific filled in by the funeral director,

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

-		(7	106 Virginia Avenue.	Jumberiand, MD 21502	
	23a. Par 1. Ente the dis a e, or comp	plications that caused the death. Do not enter the			Approximate Interval Between Onset and Death
	Immediate Cau e (Final /	END DWET	YAL CAPLINON	NA	Onot and Dount
	resulting in de h)	Due to (or as a consequence of):			
5	Sequentially list conditions,	b. — Due to (or as a consequence of):			-
	cause. Enter Underlying Cause (Disease or injury				
LVa	that initiated events resulting in death) Last	Due to (or as a consequence of):			
5		d			
	IF FEMALE:				
Sicialian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ✓ o		ppic pregnancy er (specify)	23d. Date of Month	delivery Day Year
		ontributing to death but not resulting in the underly	ring cause given in Part I	23e. Did tobacco use contribut	e to the cause of death?
2	Part II. Other Significant Conditions of	online and the control of the contro	mig cause given in Fart i.		Probably 40 nknow
- Landing				24a. Was an 24b. Were prior	autopsy findings availab to completion of cause of
5				performed? deat	1? /es 2 □ No
	25. Was case referred to medical		26. Place of Death (Check only one)	
	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: Nursing Home	e 5 ☐ Residence 6 ☐ Other (S	Specify)
	27. Manner of Death 1 → Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	Work?	d. Describe how injury occurred	
Columbation	3 Suicide 6 Could not be 4 Homicide determined		actory, office 28	ff. Location (Street and Number of City or Town, State)	Rural Route Number,
Calcal	29a. Certifier (Check only one) 1. CertifyIng Ph		urred at the time, date and place, a gation, in my opinion, death occurred	nd due to the cause(s) and manned at the time, date and place, and	r as stated. , due to the cause(s)
	29b. Signature and title of certifier		29c. License number	29d. Date signed (M	onth, Day, Year)
	~				

Registrar DHMH 17 Rev 1/2001

Dr

State

within 24 hours a To the Funeral D

HOP WALST RD CLYMBERLAND, MD DISCA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 20, 2009 **Physician** 1:45 A M Cuba Carmen Mendez /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Shady Grove Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 24, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 □XF Guatemala 79 219-06-8988 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examiner must be notified at 28a-f shov 1 ☐ Yes 2 → No Director MD Montgomery Gaithersburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 19402 Toran Rocks Terrace 20879 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2 □ No Specify: þ 3 Widowed 4 Divorced Hispanic Guatemalan Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 5 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Soledad Valdez Antonio Mendez Paz ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health au Important: If item 27 Is any Injury or other trau once. Patricia Barrera/daughter 19402 Toran Rocks Terrace Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Final Journey Crematory 08/20/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Going Home Cremation Service

MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 2102

Approximate Interval Between Onset and Death 21. Signature of Funeral Service Licensee MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiovascular Arrest /Medical Due to (or as a consequence of): Examiner Cerebrovascular Attack Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Diabetes Mellitus resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Hypertension Physician/Medical ending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 Wo 23d. Date of delivery atter for u 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≨</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has be irector, page 2 sl 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Wursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2∑XNo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this after death.

I Director: After this d in by the funeral d 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

completely within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weihan Wang, M.D. 15225 Shady Grove Rd. #208 Rockville, MD 20850

and manner stated.

Registrar's Signature 31. Date filed (Mont)

29b. Signature and title of certifier

Registrar

29c. License number

D67092

29d. Date signed (Month, Day, Year)

August 20, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

		1	For State Registrar	State of Ma		partment of I <i>ertificate of</i>			eg. No.	33	205.0
			1. Decedent's Name (First, Middle, L	.ast)				2. Date of Deat Month	h Day	Year	3. Time of Death
	Physicia /Medic		Willie Ja	mes Mcknig	ht			August		09	7:01 A M
-	Examin		4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of Death	1	4c. County		
ged.			Washington Adve		tal (In yrs. last birthda	If Under 1 Year	Takoma Pa		Montgomery 9. Birthplace (State or Foreign		
	Funeral		5. Social Security Number 6. 189–26–7654	Sex 7. Age	77 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, August 3	Year) 1,1931	Coun	h Carolina
	Director	+	Usual Residence of Decedent				<u> </u>				
	yland		10a. State 10b. County		10c. City, Town or	Location				11	0d. Inside City Limits 1 1 Yes 2 □ No
:	e Mar	ᅙ	DC				Washingt		0g. Citizen of W	that Coun	
	or 2	D.	10e. Street and Number		" 100	10f. Zip Code	00010	'			
	s 23a	Funeral Director	3298 Fort Linco	12. Was Decedent B		3 Was Decedent of	20018 Hispanic Origin? (S	pecify Yes or No-		ted S e - Americ	states an Indian,
_	item de	F.	11. Marital Status1 ☐ Never Married 2 ☒ Married	Armed Forces?	No.	Was Decedent of If Yes, specify Cub		o Rican, etc.)		k, White, e	
2-003b	within 72 hours after death with the Maryland ane. ane. Altan "natural" or items 23a or 28a-f show after "nust be indiffed at a Modical Examinet must be indiffed at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🗷 No	Specify:		Specify	Bla	ick
5	72 hou	Completed	15. Decedent's (Specify only highest to	Education	16a. De	ecedent's Usual Occu ive kind of work done e. DO NOT use retire	pation during most of wor		16b. Kind of Bu	siness/Ind	dustry
Z	within 7 jiene. r than "r	nple	Elementary/Secondary (0-12)	College (1-4or 5	i+) 'lin	e. DO NOT use retire ${ m C1}\epsilon$	_		Corr	ernme	nt
. 4		ខ្ញ	12th 17. Father's Name (First, Middle, La	net)		CTE		ne (First, Middle, i			111
anc		Be	Elfair Mckr					ry Jane N			
Maryland	should be filed and Mental Hyg s marked other umatic event, I	ပ္	19a. Informant's Name/Relationship		19b. M	ailing Address (Stree	et and Number or Ru	ural Route Numbe	r, City or Town,	State, Zip	Code)
	nd 2 sulth ar		Althea Elam/ Dau			4 Jo Drive				0774	
Baltimore,	ges 1 and 2 should b t of Health and Ment if item 27 is marked or other traumatic e		20a. Method of Disposition	_	20b. Place of Di	sposition (Name of crematory or other pla	ace) Au	Date gust	20c. Location -	City or To	wn, State
Ē	Pages nent of int: If its iry or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Ma	iryland Sal Cemet	ery 25,	2009	Laurel		
a	permit. Page Department of Important: If any injury of once.		21. Sign ture of Funeral Servic- Lie	censue	MLas	22. Name and Add	ress of Facility St				
n —	99 7 % 9		> MONO(1	in Mari	76511 17	4001 Benn				DC 4	20019
			23a. Part 1 Enter the disease, or conshock, of heart failure. List or	omplications that caused try one cause on each li	the death. Do not	enter the mode of dy	ying, such as cardia	tein Do	spess.		Approximate Interval Between Onset and Death
Jane	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a			140	70 7	, , , ,	-	
	Examiner		,	Due to (or as	a consequence of)						
		ie.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of)						
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C.							
o,	ficate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as	a consequence of)						
8760,	ate by hysici the bu	dical	,	d							
9	leath certific attending p	Mec	IF FEMALE:	23c. If yes, outcome	of pregnancy				23d Da	ite of deliv	erv
Box	death certif e attending d for use as	ian/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)				onth	Day Year
0	0 0 0	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9 🗆 Unknown		0 11 0 11 10 1 1 1 1 1 1 1 1 1 1 1 1 1					
υ, σ,	that ned b deta	by Pr	Part II. Other significant condition	s contributing to death b	out not resulting in t	ne underlying cause g	given in Part I.				he cause of death?
<u>rd</u> s	w requires been sig should be	q pe						1 🗆 Y	res 2 □ No	3∏ Pro	bably Dinknown
900	The law requires that the ate has been signed by thoage 2 should be detache	Completed						24a. Was		Were aut	opsy findings available ompletion of cause of
œ e	The late has	mo							rmed? 2 Ditio	death? 1 🗆 Ye s	2 🗆 No
/ita	ician: The certificate ector, pag	Be (25. Was case referred to medical examiner?	11			Nelson:	eath (Check only o			
of \	ding Physician: The n. After this certificate h funeral director, page		1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpati 28a. Date of Inj	ient 2 ER/Outp ury 28b. Tir	atient 3000A	4 🗆 Nursing	Home 5 ☐ Resid	dence 6 Ot now injury occur		ify)
u (ding F	ion	1 Natural 5 ☐ Pending	(Month, Da		ıry W	ork? □Yes 2□No		,e.,		
Division of Vital Records,	or Attending Physician: after death. Director: After this certific I in by the funeral director, I	ficat	3 Suicide 6 Could no	ot be 28e. Place of In	jury - At home, farn	n, street, factory, office				ber or Ru	al Route Number,
<u>S</u>	al or / s after il Dire	Certification: To	4 Homicide	building, e	tc. (Specify)			City or Tov	vii, State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical (29a. Certifier 1 Certifying (Check only one)	Physician: To the best examiner: On the basis and manner s	of examination and	death occurred at the or investigation, in m	e time, date and pla y opinion, death occ	ce, and due to the curred at the time,	cause(s) and n date and place	nanner as , and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	-77+/-t.	6 M.D	1	ense number		29d. Date sign	1 -	, Day, Year)
			James 12	Indea	F		2326		8/20,	107.	
R	10		30. Name and address of person w				ue Takom	a Park, l	Md. 20	912	

State Registrar

31. Date filed (Month, Day, Year)

AUG 2 4 2009 Security D. Apare

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Aug 28, 2009 8:15PM [™] McHugh Helen Dorothy 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Allegany 106 Potomac Street Cumberland Date of Birth (Month, Day, Ye Jan 26, Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year 1□M 2□x 219-14-5092 85 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State MD Allegany Cumberland 1 □ Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 106 Potomac Street 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1□Yes 2□No Specify: Specify: white 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Celanese Corp. conning dept. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carrie M. Hess John A. Hess 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 106 Potomac Street Cumberland daughtei Bonnie Duncan 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 8/31/2009 MD Cumberland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nce of): nce of): nce of)

Physician /Medical Examiner

physician and the burial-transi

attending p

been signed by the should be detached

certificate has I rector, page 2 s

After

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.

Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "hotel Even Incrinal to ance.

Baltimore, Maryland 21215-0036

Completed by Medical Certification: To Be

9 Unknown

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequer
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c
dical		d
sician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No.	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea

nancy tal death death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	

23d. Date of delivery Month Year

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

.	1 □ Yes 2 🛚	140
-	24a. Was an autopsy performed? 1 □ Yes 2 □ No	24b.

Were autopsy findings available prior to completion of cause of death? 1 ∐Yes 2 □ No

3 Probably 4 Unknown

25. Was case referred to	o medicai					20.	Place of Dea	atti (Check Only One)	
examiner? 1 ☐ Yes 2 ☐ No	- 1	Hospital:	1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🔲	DOA Other: 4	□ Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. Manner of Death 1 Natural 5 2 ☐ Accident	☐ Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □ Yes	2 □No	28d. Describe how Injury occurred	
3 ☐ Suicide 6 [4 ☐ Homicide	Could not be determined	28e.	Place of Injury - At he building, etc. (Specif	ome, farm, stree fy)	t, facto	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)	;
20a Cortifice 1	Cartifying Phy	releian:	To the best of my kno	owledge death of	occurr	ed at the time. d	date and place	e, and due to the cause(s) and manner as stated.	

	1		1			
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner and manner stated.						
29b. Signatura and	d title of certifier		29c. License number		29d. Date signed (Month, Day, Year)	

DOD64167

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOOMEMORIALAVE CUMBERIAM

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 9:10 A M 17, 2009 Mary Nelson August 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Rockville Montgomery Shady Grove Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea March 6, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🛣 F 1930 Texas 465-40-3299 79 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 1 ☐ Yes 2 No Montgomery Montgomery Village 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe USA 20886 19301 Watkins Mill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 □Yes 2X No Specify. Specify: White 3 ☐ Widowed 4 🌠 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cashier Barber Shop 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (unk) Cremona 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Nash/son 598 Oueens Mirror Circle Casselberry, FL 32707 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 08/22/09 | Woodbine, MD 4 Donation 21. Signature f Funeral Service Licensee coing Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) LVUS Due to (or as Sequentially list conditions, if any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as Due to (or as a consequence of metra ly disease IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Nnknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 □ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

Be

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

of 2 should be filed within 72 hours after death with the Marylan filt and Mertal Hygiene. The marked other than "natural" or items 23a or 28a-f show traumatic event, the Madical Exemplear must be notified at

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev

Physician: The law requires that the death certificate be executed and physician the as for signed by the a peen has page

Box 68760.

o

۵.

Division of Vital Records,

Examiner Physician/Medical þ Be Completed Medical Certification: To After this iours after death.
neral Director: Af

To the Hospital within 24 hours a To the Funeral I completely filled

or Attending

Hospital

(2)a2

6 Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA . Date of Injury (Month, Day, Year) 28b. Time of 5 ☐ Pending investigation

28c. Injury at Work?

1 ☐ Yes 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 🗆 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

0850

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10110 egistrar's Signature

and manner stated

1 ☐ Yes 2 No

27, Manner of Death 1 Natural 2 Accident

3 🗌 Suicide

29b. Signature and

29a. Certifier (Check only one)

4 Homicide

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#20loper FH, 8–21–09, BMW, MoCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Vear **Physician** 9:20 A^M Newman Neil 2009 August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Potomac Manor Care Potomac 9. Birthplace (State or Fore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Now 30 , YE 947 Hours Months Days Min. WasWington, DC 1 ★M 2 □ F 61 214-52-7090 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Bethesda Director Montgomery 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number U.S.A. 20817 7221 Hidden Creek Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after (Health and Mental Hygiene.
 tem 27 is marked other than "natural". or Item 1 XYes 2 No 1970− If Yes, Give Year or Dates: 1974 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Leasing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Miller ပ Samuel B. Newman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7221 Hidden Creek Road, Bethesda, Maryland 20817 Jay Freedman/Brother-In-Law Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 8-23-2009 5/23/2009 Clarksburg, Maryland 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remem. 22. Name and Address of FacilityEdward Sagel Funeral Direction 21. Signature of Funeral Service Licensee 1091 Rockville Pike, Rockville, Maryland 20852 mo1255 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Weeks Physician Respiratory Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Weeks Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Weeks Electrolyte Imbalance burial-tran Due to (or as a consequence of): attending physician for use as the buria Months Physician/Medical Decubitii e asn IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□ I Inknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown End Stage Dementia 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a, Was an Failure to Thrive cate has I autopsy performed? certificate 2 3No director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Be Hospital: Other: 4 → Nursing Home 5 □ Residence 6 □ Other (Specify) 1 Yes 2K No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient မ After this funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 ☐ Pending investigation 1 🖾 Natural 1 ☐ Yes 2 ☐ No Director: / 2 Accident

6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

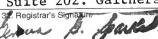
29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of Certifier August 19, 2009 D19609

Raman R. Tuli, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10810 Darnestown Road Suite 202. Gaithersburg, Maryland 20878

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 21



Saltimore, Maryland 21215-0036

law requires that the death certificate be executed

P.O. Box 68760.

Division or Vital Records,

Physician:

or Attending

death.

hours after Hospital the Funerai

24

2 2

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ian	1 - For State Registrar			•	artment of I rtificate of				eg. No.	19	28554	
	1. Decedent's Name (First, Midd	le, Last) Phillips	Sr.					2. Date of Deat Month August	Day	Year	3. Time of Death	
cal ner	Richard W. 4a. Facility Name (If not institution				4b. City, Town, o	or Location of		anagas c	16, 200 4c. County of		5:30 P M	
	13 A Ash Driv	ve			-	Knoxv					erick	
	5. Social Security Number 218-30-9112	6. Sex 1 ∐MM 2 □ F	7. Age (In yrs. 74	läst birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Oct. 29	, 1935	Year) 9. Birthplace (State or Foreit Country) Maryland		
ŏ	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo						1	0d. Inside City Limits	
Director	Maryland Fred	derick			Knoxvi	lle		1	0g. Citizen of W	hat Coun		
	13 A Ash Drive				217	58			United	Stat	tes	
Lallera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hisp If Yes, specify Cuban, I							cify Yes or No- lican, etc.)		- Americ	can Indian, etc.	
2	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive	59	1∐Yes 2 X No			Specify:	hite			
Dele	(Specify only highe	nt's Education est grade completed,		ı (Give	dent's Usual Occu kind of work done DO NOT use retire	durina most	of workin		16b. Kind of Bus	siness/Inc	dustry	
Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)	Mech	anic				Au	tomo	tive	
a D	17. Father's Name (First, Middle,	•							Maiden Surname))		
0	Melvin W. Ph:			10b Mailir	ng Address (Street	I		ne Olde		State Zin	(Cade)	
	Martha Phillip				A Ash D						o Code)	
	20a. Method of Disposition	0 Domesti from		Place of Dispo cemetery, crer	sition (Name of natory or other pla	ice)	Da	ate	20c. Location - 0	City or To	wn, State	
	4 Donation 5 Other (5		Br		11e Ceme						e, Marylan	
	21. Signature of Funeral Service	Licensee	11-		2. Name and Addre	•						
	23a. Fart 1 Enter the disea e,	r complications that	ed the deat		1100 Nor					• MD	Approximate	
	show, or heart failure. List Immediate Cause (Final	t only one cause on	each line.	4		1				Vs	Interval Between Onset and Death	
	disease or condition resulting in death)	a. Due to	(or as a conseq	uence of).	alles							
	Sequentially list conditions,	b	Lung		ancer					_		
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):								
Examine	that initiated events resulting in death) Last	c	(or as a conseq	uence of):						-		
		d										
2	IF FEMALE:	00-16										
r i i y si ci al i i i i i e al cal	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	atcome of pregna birth 2☐ Feta gnant at time of c nown	Ideath 3	Ectopic pregnan Other (specify)	cy			23d. Date Mon		ery Day Year	
Dy Pr	Part II. Other significant conditi	ons contributing to	leath but not res	ulting in the u	nderlying cause gi	ven in Part I.		23e. Did tol	pacco use contri	bute to th	he cause of death?	
								1 □ Y€	s 2 No	3 ☐ Prob	oably 4 Unknown	
Completed								24a. Was a	y p	rior to co	psy findings available impletion of cause of	
								perform 1 🗆 Yes	ned? de 2 □ No 1	eath? □Yes	2 🗆 No	
Φ	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Otl	nor:		(Check only on				
П	27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time of	28c. Inju	iry at			ence 6 Othe		fy)	
2	1 Natural 5 □ Pendir 2 □ Accident investi	ng (Mor igation	nth, Day, Year)	Injury	Wo	rk?]Yes 2□N						
0	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	e of Injury - At ho ling, etc. <i>(Specif</i>	ome, farm, str	eet, factory, office		2	8f. Location (St City or Town	reet and Numbe n, State)	er or Rura	al Route Number,	
0	4 ☐ Homicide determ	build					d place a	and due to the c	ause(s) and ma	nner as s		
Certification, 10 D	29a. Certifier 1 Certifyi	ng Physician: To th	e best of my kno basis of examina nner stated.	wledge, deat ition and/or in	n occurred at the t vestigation, in my	ime, date an opinion, deat	th occurre	ed at the time, d	ate and place, a	nd due to	o the cause(s)	
Certification: To B	29a. Certifier 1 Certifyi (Check only 2 Medical	ng Physician: To th Examiner: On the and mar	basis of examina	wledge, deat tion and/or in	occurred at the tovestigation, in my	opinion, deat	th occurre	ed at the time, d	ate and place, a	nd due to	o the cause(s)	
Certification: To B	29a. Certifier (Check only one) 29b. Signature and title of certifie	ng Physician: To the Examiner: On the and mar	basis of examina	tion and/or in	vestigation, in my	opinion, deat	th occurre	ed at the time, d	ate and place, a	nd due to	o the cause(s)	
Medical Certification: To B	29a. Certifier (Check only one)	ng Physician: To the Examiner: On the and mar	basis of examina	n 23a) (Type,	29c. Licen V Print) 510 Bull	opinion, deat	th occurre	ed at the time, d	ate and place, a	nd due to	Day, Year)	

DHMH 17 Rev 1/2001

ORIGINAL

	-	For State of Menuscript St	Maryland / Depa er FH #26 <i>Cei</i>			KB Re	g. No.	0 005	
Physici /Medic		1. Decedent's Name (First, Middle, Last) LEYEN THI PI	HAN			2. Date of Death Month August	8, 2009		
Examin		4a. Facility Name (If not institution, give street and number Frederick Memorial Hosp		4b. City, Town, or Le Frederi			4c. County of D		
Funeral Director		5. Social Security Number 6. Sex 7. 1 ☐ M 3☐ F 7.	Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct 14,	Year)	Birthplace (State or Foreign Country) Letnam	
Maryland -f show	tor	Usual Residence of Decedent 10a. State Maryland Tob. County Frederick	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes ��� No	
with the	al Director	10e. Street and Number 102 Sunlight Drive		10f. Zip Code 21702		10	g. Citizen of What USA	Country?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show apply injury or other traumatic event, it is Maries Examination in with a sonce.	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □ Divorced 1 □ Ves, Give Year or Date	No	Was Decedent of Hisp If Yes, specify Cuban, 1 □Yes 2☑No	panic Origin? (Spe Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, /hite, etc. Vietnamese	
d within 72 hours aft giene. er than "natural", or , ir elledies Exami	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Seamstress 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dressmak								
d be filed wental Hygie ked other t	To Be Co	17. Father's Name (First, Middle, Last) Ireneus Theologidy	Seams	stress	18. Mother's Name	(First, Middle, N		-8	
nd 2 should be file alth and Mental Hy 27 is marked oth r traumatic event	ř	19a. Informant's Name/Relationship (Type. Print) Dat Phan - husband		ng Address (Street ar					
rmit. Pages 1 ar partment of Hea portant: If item y injury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify)	ate I	osition (Name of matory or other place) Crematory) ;		20c. Location - City Frederic	or Town, State k, Maryland	
permit. Departr Imports any inju	0	21. Signature of Funeral Service Licensee	eline 16	2. Name and Address 521 Opossur	mtown Pi	ke, Fred		aryland 2170	
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rificate be executed g physician and as the burial-transit	edical Examiner	Due to (or Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or d.	<i>a</i>	7 years					
death cei e attendir d for use	Physician/Med	23b. Was decedent pregnant 1 Live bir	nt at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of Month		
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The ate h	Completed					24a. Was a autops perform	med? dea 2 No 1	re autopsy findings available or to completion of cause of th? IYes 2 No	
ding Physician; Th n. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inn	patient 2 ER/Outpatie	Othe	26. Place of Deat r: 4 ☐ Nursing H		ence 6 □Other	(Specify)	
ing After	Certification: To	2 Accident investigation 3 Suicide 6 Could not be	Injury Day, Year) 28b. Time of Injury Injury f Injury - At home, farm, st	M 1 □ Y	at ? ′es 2 □ No		ow injury occurred	injury occurred at and Number or Rural Route Number,	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral or the funeral		4 Homicide determined building	g, etc." (Specify)	ath occurred at the tim	ne, date and place	City or Tow	n, State) cause(s) and mani	ner as stated.	
the Hos nin 24 h the Fun tpletely	Medical	(Check only 2 Medical Examiner: On the bas	sis of examination and/or i	investigation, in my op	oinion, death occu	rred at the time, o	date and place, and	due to the cause(s)	
To 1 To 1	×	29b. Signature and title of certifier	- in	29c. License		A	Augus t		
6		30. Name and address of person who completed cause Kanan Hudhud 468 Th	of death (Item 23a) (Type	n. Print)					
St	ate		gistrar's Signature						

DHMH 17 Rev 1/2001

ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giye street and number) 0092 10146 COLUM 6 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 9. Age (In yrs. last birthday) 8. Date of Birth 6. Sex Days 09/104/71911 Pennsylvania 1 ☐ M 2 🕱 F 91 090-07-6025 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Ellicott City MD Howard 1 ☐ Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21042 10177 Maxine Street . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rebecca Stein Morris Pearl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ellicott City, MD 21042 10177 Maxine Street Marilyn Kulansky-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State 08/21/2009 Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gdns 22 Name and Address of FacilityDanzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licensee Chapels, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Doset and Deat Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month 12 months? 2 No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No ☐Other (Specify)

hysician /Medical Examiner

and

Physician /Medical

Examiner

Funeral

Director

an "natural", or items 23a or 28a-f show Medical Exaπiner must be notified at

Director

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Completed

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be filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any injury or other traumatic event at any injury or other event at any injury or o

Baltimore, Maryland 21215-0036

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Certification: To

Medical

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filled in by

completely within 24 To the F

Physician: The law requires that the death certificate be executed

Hospital or Attending

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Division or Vital Records, P.O. Box 68760,

in the past 1 ☐ Yes 9 ☐ Unknow
Dort II Othor old

25. Was case refe	rred to medical		26. Place of Death Check onl one								
examiner? 1 ☐ Yes 2	No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3 🗆 🛭	OOA Other: 4	Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)				
27. Manner of Dea 1 Natural 2 Accident	th 5 Pending investigation	28a. Date of Injury (Month, Day Yo	ear) 28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes		28d. Describe how injury occurred				
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury building, etc. (8	- At home, farm, stree Specify)	t, facto	ory, office		28f. Location (Street and Number or Rural Route Number City or Town, State)				

29a. Certifier

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

cause of death (Item 23a) (Type, Print) ess of person who 30_Name and add

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 19, 2009 Year 12:20 рм Physician Donald Eugene Perry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Frederick Emmitsburg 23 Park Drive 8. Date of Birth (Month, Day, Apr 13, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Months Days Pennsylvania 1**X**M 2□ F 49 1960 173-50-0819 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evantine units be neithed anonce. 10a. State 10b. County 1 Yes 2 No Emmitsburg Director Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21727 USA 23 Park Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Flooring Installer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy E. Wiekert William John Perry ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
23 Park Drive, Emmitsburg, MD 21727 19a. Informant's Name/Relationship (Type. Print) Donna Shriner, sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of South) crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Winfield, MD 8/20/2009 Carroll Crematory 4 ☐ Donation 5 ☐ Other (Specify) Myers-Durboraw Funeral 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 210 W Main St, Emmitsburg, MD 21727 Home Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Six morm. Immediate Cause (Final ung **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examinet To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? 5 Cher (specify) s been signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has b page 2 st autopsy performed? Yes 20 No certificate 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier WJL hingten Rd, # 204 wastmuster 30. Name and address of person who completed caus e of peath (Item 23a) (Type, Print)

State Registrar

AUG 21

1941 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 28 1041 A^{M} August 2009 Elizabeth Marie Purdie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ceci1 E1kton Union Hospital 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year **Funeral** Months Days Hours 1 □ M 2 🖔 F Yrs. OCT 12. 1942 Maryland 66 Director 215-40-0372 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Eventhan in at be notified at 1 X Yes 2 No Director Maryland Ceci1 E1kton 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21921 104 Quail Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White, etc. 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1∐Yes 2XINo Specify: Specify: by B1ack 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Automobile Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Assembler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bessie M. Wilson George W. Givens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 228 W. Williams Road, Elkton, MD Valerie Cooper/Daughter 20b. Place of Disposition (Name of competery, crematory or other place)
Bohemia Manor September 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1, 2009 Chesapeake City, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemeterv 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Sign ture of Funeral Service Licensee 103 W. Stockton Street, Elkton, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician reu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner auccetin Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed transit mxixcoud and Due to (or as a consequence of) ending physician a P.O. Box 68760. Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 menths? 5 Other (specify) ☐Yes 2 No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed melles 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 21 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → 2 ER/Outpatient 3 DOA 1 patient Medical Certification: To nours after death.

neral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide e Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) man st MD

DHMH 17 Rev 1/2001

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State

Registrar

32. Registrar's Signature

2009

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31. Date filed (Month, Day

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 5:30 a M **Physician** 18 2009 Jacqueline Ratner August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Hebrew Home of Greater Washington Rockville Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2 X F Yrs. June 24, 1926 Pennsylvania Director 193-20-4864 83 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 1 □Yes 2 k No Director Alexandria Fairfax Virginia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 22307 U.S.A. 7504 Park Terrace Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: þ White 3 X Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 1 7 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 ment of Health and Mental Molly Kramer Samuel Lichow 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 10325 Windsor View Drive, Potomac, Maryland 20854 Department of Health Important: If item 27 any injury or other tr Daniel Ratner - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 ■ Removal from State 08/19/2009 Falls Church, Virginia King David Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease shock, or heart failure. List one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 mopths? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) ☐Yes 2☐No P.O. the 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 No 2 No certificate 1 Tyes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2, No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To funerai 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by determined 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

			For State Registrar	State of N	Maryland /		artmen <i>tificat</i>			and M	ental F		ne No. 4 ()	09	20	560
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	Funeral		5. Social Security Number 6. Se	ex 7. /	Age (In yrs. last	birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of	Birth Day, Ye	ar)	9. Birthp	lace (State o	or Foreign
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Baltimore,	# 분 보 등		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		Parion								pel,			
ä	permi Depar Impor any ir		Ment										nster		2115	7
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caus	sed the death. I										Approximat	te tween
	Physician		Immediate Cause (Final disease or condition	00	0.00	4. 4.		Pus	BA	111	lin	4			Onset and	Death
ja.	/Medical		resulting in death)	a. Due to (or	as a consequen	ice of):	-cau	ريا جعمار		en	<u></u>				2	
	Examiner		Sequentially list conditions	b. 02	enne	ne	1								Juli	u
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequen	ice of):	0		10		lay K	Λ.			·	
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Cut	as a consequen	LII.	alic		Va	zul	ey h	vise	ne		7	1
8760,	be ex cian burial			Due to (or	as a consequen	ice oi).										
87	physi physi the	dical	•	d												
9 X	leath certific attending p I for use as I	/Me	IF FEMALE:	23c. If yes, outcor	me pf pregnancy	у							23d. Dat	e of deliv	erv	
Box	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetal de t at time of deat		⊒Ectopic p ⊒ Other <i>(s</i> (<i>'</i>			_	Мо			Year
0	at the de by the	Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown	9□Unknowi	1											
σ,	s that ned b	by Pi	Part II. Other significant conditions of	ontributing to deat	h but not resultir	ng in the u	nderlying o	cause giv	en in Part I		23e. [Did tobac	co use cont	ribute to 1	he cause of	death?
Records,	quires in signi uld be										•	☐ Yes	2 No	3 ☐ Pro	bably 4 🗆	Unknown
ပ္တ	aw requir s been s s should	Completed										Vas an	24b. \	Were aut	opsy findings	available
æ	The lay	E										autopsy performe	d? d	death? ∐Yes	mpletion of o	ause or
Vital		Be C	25. Was case referred to medical						26. Place	of Deatl	h (Check o		200			
<pre>> </pre>	di is	.0	examiner? 1 □ Yes 2 ⊠ No	Hospital: 1 ☐ Inp	atient 2□ER	R/Outpatie	nt 3 D	Oth	er: 4 🗷 Nu	ursing Ho	me 5 🗆 I	Residenc	e 6 🗆 Oth	er (Speci	fy)	
1 O.		n: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month,	njury 28 Day Year)	Bb. Time of	of :	28c. Injur Wor	y at k?		28d. Desci	ibe how	injury occur	ed		
iõ	Attending or death. ector: After by the fune	atic	2 ☐ Accident investigation				М	1 🗆	Yes 2□	No						
Division	두 후 후 ㄷ	Certification:	3 Suicide 6 Could not be 4 Homicide determined	20e. Flace of	injury - At home , etc. <i>(Specify)</i>	e, farm, st	reet, factor	y, office				on <i>(Str</i> ee r Town, S		er or Rui	al Route Nur	nber,
	oital c urs af eral D					eCi. to a							(-)			· · · · · · · · · · · · · · · · · · ·
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier 1		s of examination											(s)
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner	Stated.		29	c. Licens	e number			29d	. Date signe	d (Month	Day, Year)	
	_		John 40 (Dull	leton 1	(i)		7) 2	174	42		5	2/17	120	19	
	WJL		30. Name and address of person who	completed cause of	of death (Item 23	3a) (Type	Print)	~!	- /	1			-		/	
)		John W. Middle	ton 3	337 V	wh	ry-S	tre	et	0	non	lu	Da -	MI) 2/1	02
	Sta	ate	31. Date filed (Month, Day, Year)		istrar's Signatur	е							1			
	Regist	rar	AUG 18	2009	eneva	B.	park	1								
DH	MH 17 Rev 1/2	2001		*			•									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #11, 8-24-09, per FHDR, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 19 10:05 2009 Delores Lorraine Sowers August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Smithsburg 11721 Kieffer Funk Road Washington Birthplace (State or Foreigr Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex **Funeral** Months Min. Days Hours 1 □ M 2 💢 F Feb 4, 1932 Director Maryland 220-28-4136 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the "fadical Expriner must be nutified at 1 ☐ Yes 2 No Director Washington Smithsburg 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 11721 Kieffer Funk Road 21783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2√▼ No Specify. þ 3 ₩Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other trainmetic." Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Theodore Martin Myers Helen Irene Marshall 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Douglas F. Sowers/son 11733 Kieffer Funk Road Smithsburg, MD 21783 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 08/20/09 Woodbine, MD 21. Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 23a. Part 1. Enter the recase, or complications that caused the death. Do not enter the mide of dying, such as carriac or respiratory arrest.

| Interpretation | Proceeding | Procedure | Immediate Cause (Final disease or condition resulting in death) . Physician Colon CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) the detached 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 71No has page 2 : 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification: To this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

Division of Vital Records, sompletely filled in by the funeral dir Hospital or Attending 24 hours after death. Funeral Director: A within 2

State

29b. Signature

Date filed (Month

30. Name

Registrar DHMH 17 Rev 1/2001 address of person who completed cause of death (Item 23a) (Type, Print)

MA

32 Registrar's Signature

REEd

29c. License number

22911 Jefferson Blud. Smithsburg, MB

29d. Date signed (Month, Day, Year)

August 19, 2009

Please Type or Print in Black Indelible Ink. Ensure All (Apples Are Legible.

Amend, Items 23e & 24a per phys. G893 All (Apples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	Olato of Mai	ryiaria / D	Cert	ificate of l	Death	Re	eg. No.	000	200	55.7	
	Physici	1. Decedent's Name (First, Middle, Last) MILDRED RUTH SCHAEFER 2. Date of Death Month August 18,										3. Time of 8:40	Death P M	
1	/Medic	al	4a. Facility Name (If not institution, give		RUTH SC			Location of Death	August		2009	0:40	Рм	
	Examin	er	Citizens Care & Re		ion Ctr		Frederi				ederic	k		
	Funeral Director		217 22 3023	ex 7. Age ☐ M 2 🙀 F	(In yrs. last birti	hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 7	, 191	9. Birthp Cour Mar	lace (State on htry) yland	or Foreign	
	and ow t		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	ation				1	0d. Inside C	ity Limits	
	a-f she	ctor	Maryland Frederic	ek	Frede	rick						1 XYes	2 🗌 No	
	or 28	Director	10e. Street and Number				10f. Zip Code	702	1	_	of What Cour	ntry?		
	leath v ns 23a must	Funeral	1900 Rosemont Avei	12. Was Decedent Ev	ver in U.S.	13. W		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		Race - Americ	an Indian,		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give Year or Dates:			37	an, Mexican, Puerto Specify:	Rican, etc.)		Black, White, ecify: Whi			
5-0	"natu	letec	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a.	Decede	ent's Usual Occup ind of work done of O NOT use retired	ation during most of work d)	ing	16b. Kind o	of Business/Ind	dustry		
212	Specify: Specify:								sing					
ng	be filed tal Hyy d othe event,	Be	17. Father's Name (First, Middle, Last) William Franklin l	r_411				18. Mother's Nam	_{e (First, Middle, N} u i se Cal		name)			
<u> </u>	hould I d Men marke matic	ဥ	19a, Informant's Name/Relationship (7		19h	Mailing	Address (Street	and Number or Rui			wn State Zir	Code)		
<u>N</u>	nd 2 sl alth an 27 Is i		Richard Bucheimer			_		y Court,						
Baltimore,	Pages 1 a nent of He int; If item iry or othe		20a. Method of Disposition		20b. Place of cemeter,	Disposi y, crema ven	tion (Name of atory or other place Mem. Gan	dens 8/2			on-City or To		ıd	
Balti	permit. Departn Importa any Inju	21. Signature of Funeral Service Licensee. PUBERT E DAILEY & SON FUN 1201 NORTH MARKET STREET,									FREDERICK, MD 2			
	Physician		23a. Part 1. Enter the disease, or complications th t carsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Approximate interval Between Onset and Death Conset and Death Co											
/Medical resulting in death) Due to (or as a consequence of):								r 1 1				11.6		
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	cuted nd ansit	Examiner	Sequentially list conditions, france cause. Enter Underlying Cause (Disease or injury that initiated events	C.		,								
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68760,	rtificate be executed ng physician and as the burial-transit	Medical		.d										
P.O. Box (ath ce attendii or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	Fetal death		Ectopic pregnand Other (specify)	у		23d	. Date of deliv Month		Year	
۰, ص	res that the de signed by the a l be detached f	by Ph	Part II. Other significant conditions of		not resulting in	the und	derlying cause giv	en in Part I.	23e. Did tol	bacco use	contribute to t	he cause of	death?	
örg	w require s been sig should b	ted b	Dema						1 □ Ye	s 2 [*] ⊡ N	lo 3∏ Pro	bably 4 🗍	Unknown	
ll Rec	The law rate has be	Completed	Coros	uny and	ery	<u>D1</u>	Live		24a. Was a autops perform	ned?	death?	ppsy findings impletion of a 2 \Begin{align*} No	available cause of	
Zi ta	siclan: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			3□ DOA Oth		th (Check only on					
ō	ding Physician: The In. After this certificate hit funeral director, page	n: To	1 Yes 2 No 27. Manner of Death	1 ∐ Inpatien	t 2 ☐ ER/Out	Time of	3 DOA 28c. Injur	4-ELYVUISING TH	ome 5 Reside			fy)		
Division of Vital Records,	l or Attending after death. Director: Aft I in by the fun	Certification: T	1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined		ry - At home, far	njury rm, stre	M 1□	Yes 2 □ No	28f. Location (Si City or Town		umber or Run	al Route Nur	mber,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical Ce		ysician: To the best of niner: On the basis of and manner stat	examination an								s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier				29c. Licens		2		igned (Month,			
			> Custin	Learn			Do	9689		01	20/00	1		
			30. Name and address of person who							1701				
	Sta	te	Austin Pearre, MD 31. Date filed (Month, Day, Year)	32. Registra	's Signature			rick, Mar	-	1701				
	Registi		106 2 0 2009 Denes	m BA	- Constant	u	estin 1	barre	-					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Physician August 20, 2009 5:25 Α Dr. James E. Stoner, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Northampton Manor Nursing Home Frederick If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yea June 25, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1 N M 2 □ F 1918 Maryland Director 219-03-2131 91 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Medical Eventine must be redified at any injury or other traumatic event, the "Medical Eventine must be redified at any once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1X Yes 2 ☐ No Director Maryland Frederick Walkersville 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 21793 United States 28 Fulton Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 □ No WWII If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Family Practice Physician 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မ James E. Stoner Hazel Eyler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Walkersville, MD 21793 28 Fulton Ave., Eliza_Stoner / Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐X remation 3 ☐ Removal from State 8/21/2009 Stauffer Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signarule of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the disease, or complications that goused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a o 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown HYPER CALCEMIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No Jas his certificate ha 1 ☐Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27, Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending n 24 hours after death, ne Funeral Director: Aft bletely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 TAccident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in revenience death. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32171 8/21/09 15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUX 328 PO 2,793 WALKERSUILLE MD RICHARD GOUGH 2 32. Registrar's Signature 31. Date filed (Month, Day, Year) State acke Registrar

			For State Registrar	ate of Maryland		rtment of H tificate of L			iene eg. No	n c	28564		
	Physicia		Decedent's Name (First, Middle, Last) Harold Sweed					2. Date of Dea Month Aug	th 17 200)9 ^{Year}	3. Time of Death 21:00 M		
7	/Medic Examin		4a. Facility Name (If not institution, give stree Shady Grove Adventis			4b. City, Town, or Rockvill	Location of Death		4c. County	y of Death	У		
	Funeral Director		5. Social Security Number 6. Sex 12M	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 4	, Year)_	9. Birthpl Coun North	lace (State or Foreign try) Dakota		
	ъ	or	Usual Residence of Decedent	10c. City, 1						10	0d. Inside City Limits 1 Yes 2 No		
	with the Paa or 28a- st be notifi	I Director	10e. Street and Number 15208 Gravenstein Wa		1000	10f. Zip Code 20878		1	0g. Citizen of	What Coun	itry?		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral	1 ☐ Never Married 2 ☑ Married	Vas Decedent Ever in U.S. urmed Forces?	<i>r</i>	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🔀 No	ispanic Origin? (Spanic Origin? (Spanic Origin) (Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No- pecify Yes or No-		ce - Americack, White, of			
Maryland 21215-0036	vithin 72 hou ene. than "natura he Medical E	Completed	15. Decedent's Educatio (Specify only highest grade co	n l	(Give life. I	dent's Usual Occup kind of work done o DO NOT use retired grapher	ation during most of work l)	king	16b. Kind of B	Business/Ind Govenn			
land 2	ild be filed v lental Hygie ked other i ic event, th	To Be Co	17. Father's Name (First, Middle, Last) Nathan Sweed			52 49 110 1	18. Mother's Nam Rose "I	ne (First, Middle, Unknown''	Maiden Surna	me)			
, Mary	and 2 shou saith and M 27 is mar er traumat		19a. Informant's Name/Relationship (Type. Karen Rumeld/Daught		19b. Mailir 13602	ng Address (Street 2 Daphney	and Number or Ru House Co	ral Route Numbe ourt. Ro	ckville	e, MD	20850		
altimore,	Pages 1 ament of He ant; If Item		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	cen	netery, crei g Dav	sition (Name of matory or other place id Mem Gr	ds. 08/19		20c. Location Falls (Church	n, VA		
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Lisensee	2/6	10	2. Name and Address 2. Name and Address 2. Name and Address 3. Nam	ille Pik	e. Rockv	ille, N				
	Physician /Medical Examiner	0.50	Interval onset all uses on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Dysphagia										
8760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner											
P.O. Box 68	the death certific r the attending p ched for use as f	Physician/Mec	in the past 12 months?	f yes, outcome pf pregnand 1∐Live birth 2 ∐ Fetal d 4∐Pregnant at time of dea 9∐Unknown	eath 3	Ectopic pregnancy Other (specify)	1			ate of delive	ery Day Year		
rds, P.	w requires that the deben signed by the should be detached		Part II. Other significant conditions contrib Coronary Artery Dis					1			he cause of death? pably 4 \textsty\text{Unknown}		
Division or Vital Records,	The law recate has bee page 2 shot	Completed by						24a. Was autop perfo 1□ Yes			opsy findings available mpletion of cause of		
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	ital:	3/0-44	oth	er.	ath (Check only o					
ion or	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ition: To	27. Manner of Death **XX**Natural 5 Pending 2 Accident investigation		R/Outpatier 8b. Time o Injury	f 28c. Injui	4 LI Nursing F	lome 5 Resid			<u>19/) </u>		
Divis	tal or Atter s after dea al Director ed in by the	Certification:	C Could not be	8e. Place of injury - At hom building, etc. (Specify)	e, farm, st	reet, factory, office		28f. Location (S City or Tox		nber or Rura	al Route Number,		
	Hospi 24 hour Funer etely fill	Medical (29a. Certifier (Check only one)	In: To the best of my knowl On the basis of examination and manner stated.	edge, deat on and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occi	e, and due to the urred at the time,	cause(s) and r date and place	nanner as s e, and due t	stated. to the cause(s)		
	To the complete compl	Me	29b. Signature and title of certifier Defaue, Ra	ue' MD		29c. Licens	6 & 17 8		29d. Date sign	ned (Month,			
,	, -		30. Name and address of person who comp	eted cause of death (Item 2	3a) (Type, ville	Print)		sh Gopal					
	Sta Regist		31. Date filed (Month, Day, Year) AUG 2 1 2009	32. Registrar's Signatu	Te So	ake							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#4aperMD, 8-24-09, Brw, MCO

State of Maryland / Department of Health and Mental Hygiene

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) August 19, 2009 Year 11:20 PM **Physician** Marion SHERMAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery Village 9705 Inaugural Drive (Victoria House) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Aug. 5, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1907 Poland **Funeral** 1 □ M 2√2 F 102 577-34-6595 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ YNo Potomac Director Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20854 7922 Turncrest Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) white 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Ś 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be uth and Mental F. Edith Gurman Harry Engel ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7922 Turncrest Drive, Potomac, MD Department of Health an Important: If item 27 is any injury or other trau Alan Sherman, Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oxon Hill, MD 09/23/09 Israel Cemetery B'nai 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign. III of : n-rai Se vi ᢪ፞፞ቇኯፘዅ፞፞፞፞፞፞፞፞፞፞ኯ፞፞፞፞፞፞፞ጜ፞፞፞፞፞፞ቑ፞ኇ፨ኯ፝ቔ፞ጜቝ፝፞፞፞፞፞፞፞ቝ Funeral Home 401008 254 Carroll St., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) <u>Years</u> Physician Dementia Due to (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed and the burial-tran Due to (or as a consequence of): physician Physician/Medical use as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant Year 3 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) the Ö signed by t t be detach σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ≥ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has I page 2 s performed? Yes 2A No 1 ☐ Yes 2 No 1 ☐ Yes this certificate 26. Place of Death (Check only one)

r: Victoria's House Group Home
1 | Victoria's Residence 6 (Archip Home) 25. Was case referred to medical Be ,Assisted examiner? Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No Certification: To Living 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No

funeral To the Hospital or Attending Pl within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral After Division

1 Natural 2 Accident

29a. Certifier

3 ☐ Suicide

(Check only one)

31. Date filed (Mg

4 Homicide

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

title of certifie 29b. Signature and

29c. License number 19294

29d. Date signed (Month, Day, Year) August 20, 2009

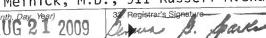
ress of person who completed cause of death (Item 23a) (Type, Print)

911 Russell Avenue, Gaithersburg, MD 20879 Melnick, M.D. John

WI

State Registrar

Medical



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month 12:12 P·M 2009 August 17. <u>Virginia Rogers Sayre</u> 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Bethe<u>sda</u> Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Year)
Nov. 28,1920 9. Birthplace (State or Foreign Country)
Kansas If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Min. Hours 1 □ M 2 🖾 F Months Davs 88 482-12-7072 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County Washington, D.C. Y Yes 2 □ No DC None 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20005 USA 1330 Massachusetts Ave., NW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 21 No Specify: Specify: White 3₺ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U. S. Mational Elementary/Secondary (0-12) College (1-4or 5+) Laboratory Public Relations 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nelle Youngman Taylor Nathan Orvey Rogers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) torney r Estate 1667 K Street, N.W., Suite 720 Washington, D.C₂₀₀₀₆ Mr. Robert Gazzola /for 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 8/19/2009 Alexandria, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home M00215 2222 Wisconsin Ave. N.W. Washington, D.C.20007 Approximate Interval Between Onset and Death 23a. Part 1. Enter the Asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Lardiovaswar Arterioscleratic disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23c. If ves. outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

nding physician and ise as the burial-tran

signed by the atte

certificate has been s rector, page 2 should

the funeral director,

this

Director:

I or Attending Fafter death.

To the Hospital of within 24 hours at To the Funeral D

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exymiter must be rediffered once.

Baltimore, Maryland 21215-0036

Exami Physician/Medical 2 Completed Be Certification:

23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 No 9 Unknown

1 Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

and manner stated.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

old Georgepun Rd. Bethesda MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

29b. Signature and little of certifier

1 Natural 2 Accident

3 Suicide

4 Homicide

29d. Date signed (Month, Day, Year)

Physician Imenency 30. Name a

Batha Venard 8500 vennard 01

State Registrar

Medical

31. Date filed (Month, Day,

6 ☐ Could not be



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05450 State of Maryland / Department of Health and Mental Hygiene Charles R. Schneider, III 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ July 12, 2009 0852 hrs Charles Raymond Schneider, III **Medical Examiner** 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Calvert Prince Frederick Calvert Memorial Hospital Birthplace (State or Foreign Country) If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 219-06-3902 Director July 19 1969 Maryland 1 X M 2 F 39 Yrs Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No 28a-f shov Port Republic or items 23a or 28a-f shore. must be notified at once. Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number United States 20676 3085 Howard Drive Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S White, etc. Armed Forces? Never Married 2 Marrie Yes Specify: white XDivorced 2 X No specify. permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", o injury or other traumatic event, the Medical Examiner II. Yes, Give Year Yes Widowed à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 mechanic automobile 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Raymond Schneider, Jr. Virginia Blevins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3085 Howard Drive Port Republic, Maryland 20676 Virginia McIntyre- mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, July 18^{D2}2009 20a. Method of Disposition crematory or other place) Alexandria Virginia Burial 2 ____xremation 3 ___ Removal from State Metropolitan Funeral Service Donation 5 Other Specify. 22. Name and Address of Facility 21 Signature of Funeral Service Licensee Rausch Funeral Home, PA 4405 Broomes Island Road Port Republic Maryland 20676 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death /Medical a Acute bronchopneumonia and methadone intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed AMENDED 23a,2/,28a-f, per ME g895 9/10/09 Physician/Medical X UNPENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown g Unknown by the a 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. á 1 Yes 2 No 3 Probably 4 V Unknown Completed this certificate has been streeter age 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed' 1 🗸 Yes No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Other; examiner? Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 1 Yes ٤ 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: subject ingested methadone __Yes 2X No Natural Pending Fd 7/12/09 Fd 0758 hrs 2 XAccident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3085 Howard St 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 Suicide (Specify) residence Fort Republic, MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: within 24 hours after death
To the Funeral Director: After this certific completely filled in by the funeral director,

31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 1/2001

State

OCME 2006

29b. Signature and title of certifier

Russell Alexander MD.

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

and manner stated

Assistant Medical Examiner

32. Regist

ar's Signature

30. Name and address of person who completed cause of death (Item 23a)

July 13, 2009

29d. Date signed (Month, Day, Year)

	1	State of Maryland / Department of Health and M = State Certificate of Death		giene Reg. No. (009	26566
		1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath Day	o Veak	3. Time of Death
Physician /Medical		Donald M.Smith	Month			
Examiner		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death			ounty of Deat Sarrol	
200	F	2336 E. Mayberry Rd. Westminster 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birt	h		thplace (State or Foreign ountry)
Funeral Director		220-26-7310 1X M 2 F 78 Yrs. Months Days Hours Min.	(Month, Da 5/21/		PÃ	
pu ,	-	Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location				10d. Inside City Limits
Maryle f shoved at		MD Carroll Westminster				1 □Yes 2 No
r 28a-		10e. Street and Number 10f. Zip Code		10g. Citize	en of What Co	ountry?
th with sist be	2	2336 E. Mayberry Rd. 21158			USA	
tems er mu		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14	4. Race - Ame Black, Whit	
hours after death with the Mar hural", or items 23a or 28a-f st al Examiner must be notified	2	1 ☐ Never Married 2 Married 1 Marri		8	Specify: W	hite
be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		15 Decedent's Education 16a Decedent's Usual Occupation	kina	16b. Kin	d of Business	/Industry
3 60 =	-	Elementary/Secondary (0-12) College (1-4or 5+)				
filed w Hygier other the	3 -	12 7 District Court Juc 17. Father's Name (First, Middle, Last) 18. Mother's Nam				system
	ĭ		1 Mill	er		
re, Maryle s 1 and 2 should t Heatth and Mer tem 27 Is marke other traumatic	-	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Re	ıral Route Numb	er, City or		
and 2 sh and 2 sh ealth and n 27 Is n wer traun		Marlene Smith / wife 2336 E. Mayberry F				MD 21158
altimore, mit. Pages 1 a partment of Hee portant: If item y injury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date		ation - City or	
ITIMOF iit. Pages artment of I ortant: If ite injury or o	ì	4 □ Donation 5 □ Other (Specify) St. Mary's Cemetery 8 21. Signature of Funeral Service Licensee	/24/09	Sil	ver R	un, MD
Baltimor permit. Pages Department of Important: If it any injury or o		Red and Little h 34 Maple Ave. L	ittles	town	, PA	17340
	+	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	c or respiratory a	rrest,	-	Approximate Interval Between
Physician	i	Immediate Cause (Final disease or condition				Onset and Peath
/Medical Examiner		Due to Ar as a consequence of):				
	_ -	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				Jupen
uted d ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury hat initiated events C. C. C. C. C. C. C. C. C. C				hien
e exectian an urial-tr	ĭ	Cause (Disease or Injury that initiated events resulting in death) Last C. Correction Hearth Reader Cause (Disease or Injury that initiated events resulting in death) Last C. Correction Hearth Reader C. Correction H	_			10
Thecords, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d Chronic Berrallandles				1 year
Box 6 leath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy		2	3d. Date of d	elivery
death cer e attendin d for use	Iclar	in the past 12 months? 4 Pregnant at time of death 5 Other (specify)			Month	Day Year
vequires, P.O.	,uys	9 Unknown	23a Did	tobacco us	se contribute	to the cause of death?
res th	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				Probably 4 □Unknown
Records, he law requires the law seem signe and be consigned.	Completed		24a. Was	an	24b. Were	autopsy findings available
The lav	d m		auto	opsy ormed?	prior to death? 1 □ Ye	completion of cause of
Vital Fician: The certificate rector, pag	Pe Pe		ath (Check only			2 110
	0		Home 5 Res			pecify)
		27. Manner of Death 1	28d. Describe	how injury	y occurred	
Olvisio	Icati	3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office	28f. Location	(Street and	d Number or i	Rural Route Number,
Div	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or 16	bwп, State,	,	
		29a. Certifier (Check only (Check only a detail examiner: On the best of my knowledge, death occurred at the time, date and place (Check only a detail examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only a detail examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only a decimal examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only a decimal examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only a decimal examiner).	ce, and due to the curred at the time	e cause(s) e, date and	and manner I place, and d	as stated. ue to the cause(s)
thin 24 thin 24 the F mplete	Medical	one) and manner stated. 29b. Signature and title of certifier 29c. License number				nth, Day, Year)
L WJZ		D37949		Au	م، کو	th 2009
12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			_	
		Alexander Proglemberston Short here Seet	reer b	reg	rube	1000, 2US
Stat Registra		All 21 2009 Linus G. Jakel				•
- negistra	1	AUG 21 2009 Cenus B. Jak				

DHMH 17 Rev 1/2001

For	State of Maryland / Department of Health and Mental Hygiene								
For State Registrar	Certificate of Death	Reg. No.							
1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day	Voor					

Physician /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Model Examiner mast be redified at another. ő

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit

Division of Vital Records, P.O. Box 68760,

1 - State Registrar	C	ertificate of Dea	ath	Reg. No.	063	21569			
1. Decedent's Name (First, Middle, Last)			2. Date of Month		Year	3. Time of Death			
Margery Louise	Scott		August	29	2009	3:00PM			
4a. Facility Name (If not institution, give street and no	ımber)	4b. City, Town, or Loca	ation of Death		nty of Death				
Homewood of Williams	sport	Williamsp			shingt				
5. Social Security Number 511-03-1325 6. Sex 1 □ M 2 ☒ F	7. Age (In yrs. last birthda	Months Days He	Onder 24 Hrs. 8. Date of (Month, May 19	Birth <i>Day, Year)</i>	Coui	place (State or Foreign ntry) ion City,KS			
Usual Residence of Decedent									
10a. State 10b. County	10c. City, Town or				1	0d. Inside City Limits			
MD Washington	Williams	sport				1X Yes 2 No			
10e. Street and Number 16505 Virginia Ave. Ap	t.B111	10f. Zip Code 21795		10g. Citizen o	of What Cour	ntry?			
11 Marital Status 12. Was Dec	cedent Ever in U.S. 1	Was Decedent of Hispar	nic Origin? (Specify Yes or		Race - Americ				
Armed F 1 Never Married 2 Married 1 Yes, G 3 Widowed 4 Divorced Year or	2 X No Give	_	exican, Puerto Rican, etc.) pec <i>ify:</i>	Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed	16a. De	ecedent's Usual Occupation ive kind of work done during	g most of working	16b. Kind of	Business/In	dustry			
	(1-4or 5+)	e. DO NOT use retired) erk typist		Federal government					
17. Father's Name (First, Middle, Last)		18.	Mother's Name (First, Mide	dle, Maiden Surn	ame)				
Edward P. Tully		Fı	cances L. Fed	chner					
19a. Informant's Name/Relationship (Type. Print)	19b. M	ailing Address (Street and I	Number or Rural Route Nu	mber, City or To	vn, State, Zip	Code)			
Sandra Oliver	10	738 Appletree	e Lane Willi	Lamsport	, MD	21795			
20a. Method of Disposition	nomotory o	sposition (Name of crematory or other place)	Date	Date 20c. Location - City or Town, State					
1 ☐Burial 2 ☐ Cremation 3 ☒ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Green H:	ill Cemetery	September 4	2009	Wayne	esboro, PA			
21. Signature of Funeral Service Liceraee		22. Name and Address of	Facility Grove-I	Bowersox	Funer	al Home, I			
James V. Dayle	real	50 S. Broad S	St. Waynesh	oro, PA	1726	58			
23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) a. Due to	caused the death. Do not each line.	enter the mode of dying, su	uch as cardiac or respirator	y arrest,		Approximate Interval Between Onset and Death			
Sequentially list conditions.	o (or as a consequence of):	a consequence of):							
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.									
resulting in death) Last Due to	o (or as a consequence of):								
d									
IF FEMALE: 23c. If yes, o	utcome of pregnancy			23d	/erv				
in the nast 12 months?	e birth 2□ Fetal death gnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	-	23d. Date of delivery Month Day Year					
Part II. Other significant conditions contributing to	death but not resulting in the	e underlying cause given in	Part I. 23e. D	id tobacco use c	ontribute to t	the cause of death?			
Mueloproliferative	Disorder o	- O . A		□Yes 2 No	3 □ Pro	bably 4 ☐ Unknown			
Diabetes Mellitus Atherosclerotic Heart Disease 24a. Was an autopsy performed? death? 1 yes 2 line 1 yes 2 line									
								25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1	Inpatient 2 ☐ ER/Outpa
27. Minne of Death 28a. Dat	e of Injury enth, Day, Year) 28b. Tim Injur	e of 28c. Injury at	Ursing Home 5 ☐ R 28d. Descri	be how injury oc					
2 Accident investigation	ini, bay, ibai) injul	M 1 ☐Yes	2 □No						
3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Street and Number or Building, etc. (Specify) 28f. Location (Specify) 28f. Loca						al Route Number,			
27. M*np* of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred									
29b. Signature and title of certifier	1-Sand nx	29c. License nu		29d. Date sig					
30. Name and address of person who completed ca	use of death (Item 23a) (Tv	pe Print)	0 h P = - 0 h	100000	town	Marialand			
Svothia Kuthner-Sano	15 mg 14214	Paradise Chi	erch road, h	ag ers	2174	2 July			

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State

Registrar

31. Date filed (Month, Day, Year)

SEP 0 0 2009

pares

32. Registrar's Signature

,	for State Registrar	State of Maryl		rtment of F rtificate of I			Reg. No.	00 285	711			
	Decedent's Name (First, Middle,	Last)				2. Date of De		3. Time of Deat	th			
Physician		Smith				AUGUST		009 2:00A	M.			
/Medical Examiner	4- Carilla Nome //f not institution	give street and number)		4b. City, Town, or	Location of	Death	4c. County of	Death				
_ Adminior	Reeders Memor	ial Home		Boons				ington				
Funeral	5. Social Security Number	6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of Bi Min. (Month, D	rth av, Year) 20,1920	9. Birthplace (State or For Country) Maryland	reign			
irector	215-34-3730	1□M 2kpF 89	Yrs.			March	20,1920	Marylano				
	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Lir	nits			
any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		ington	Boonsb					1 ∏Yes 2 □] No			
Director	Ma. Wasi	illig Coll	DOOMSD	10f. Zip Code			10g. Citizen of Wh	nat Country?				
i c				2171			U.S.					
Frineral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of H	lispanic Orig an, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race Black,	- American Indian, White, etc.				
ű		ed 1 ∐Yes 2 ZMNo If Yes, Give		1 □Yes 2□No	Specify:		Specify:	White				
2	3 Widowed 4 □ Divorced	Year or Dates:					16b. Kind of Bus	inaes/Industry				
Completed	15. Decedent (Specify only highes	s Education t grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	durina most	of working	160. Killa ol bas	iness/maasay				
8	Elementary/Secondary (0-12)	College (1-4or 5+)		omemaker	<i>u</i> /		HC	ome				
8		act)		JIII MAKEL	18. Mother	's Name (First, Middle	e, Maiden Surname)				
To Bo	Frnact Her	rman Dagenhart			l .	Grace Mari						
	19a. Informant's Name/Relationsh					r or Rural Route Num Grencastle						
	20a. Method of Disposition		0b. Place of Dispo					City or Town, State				
	1 ☐ Burial 2 🖫 Cremation	3 ☐ Removal from State	Smi thsbu	matory or other plants		ug. 30, 2009		ourg,Md.				
	4 Donation 5 Other (Sp		2	2. Name and Addre			2525 Brad	Bury Ave.				
once	21. Signature of Funeral Service	Icensee		.L. Davis		7 77		,Md. 21783				
	25a. Part 1. Enter the disease, or	complications that caused the	death. Do not en	ter the mode of dy	ng, such as			Approximate Interval Betwee	n			
	shock, or heart failure. List Immediate Cause (Final	only one cause on each line.						Onset and Deat	th			
cian lícal	disease or condition resulting in death)	a. Due to (or as a co	[THMIB					1-21/e.	•			
ner		b Due to (or as a co	_	BRILLA	ת מאי			Yeares				
	Sequentially list conditions,	b. Due to (or as a co		-S IN COM	1 0,4							
	Sequentially list conditions, in any, leading to intreal late cause. Enter Underlying Cause (Disease or injury	PHE	UMONIA					Works				
	Sequentially list containing, if any, feating to infine flate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):			•						
	diccar Car	d. Clos) ridium	Diffice	c Col	itue		near	_			
	D IC ECMALE:	-		- 1								
	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐	Fetal death 3	☐ Ectopic pregnan	су		23d. Date Mor	e of deliv <i>e</i> ry hth Day Yea	r			
,	in the past 12 months? 1 □ Yes 2 No	4 ☐ Pregnant at tim 9 ☐ Unknown		Other (specify)								
	9 ☐ Unknowh		4	malochios	hion in Port !	23a Die	I tohacco use contr	ibute to the cause of deat	 h?			
		ons contributing to death but no	ot resulting in the i	underlying cause gi	ven in Part I.			3 ☐ Probably 4 🕻 Unk				
	Completed by											
	<u>a</u>					24a. Wa	topsy p	Vere autopsy findings ava rior to completion of caus	ilable se of			
	E					pe 1 □ Yes	dormod?	leath? □Yes 2 2 No				
	 25. Was case referred to medical 				26. Place	of Death (Check only	(one)		_			
		Hospital: 1 ☐ Inpatient										
	27. Manner of Death 1 Natural 5 Pendir 2 Accident Investi 3 Suicide 6 Could determ	27. Manner of Death 1. Natural 5 Dending (Month, Day, Year) 28b. Time of Injury Work Injury Work										
e runeral dire	1 Natural 5 □ Pendin 2 □ Accident investi	gation			∃Yes 2□	No						
1	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		At home, farm, s	treet, factory, office		28f. Location City or 7	(Street and Numb own, State)	er or Rural Route Number	r,			
	- Intermedia					1						
	29a. Certifier 1 Certifying (Check only 2 Medical	ng Physician: To the best of m Examiner: On the basis of ex	amination and/or	ath occurred at the investigation, in my	time, date ar opinion, dea	nd place, and due to t ath occurred at the tim	he cause(s) and ma ne, date and place,	anner as stated. and due to the cause(s)				
	one) and manner stated. 29b. Signature and title of certifier 29c. License number						29d. Date signed	(Month, Day, Year)				
5	N N	mD mD		Λ	140	,	Aug	28 2009				
	Ju		h (Itom 20a) /T	Drint)	46501		TING	21,000				
	30. Name and address of person	wno completed cause of death	n (item 23a) (Type	AD DOOM	SRADA	MARYLAND	21713	301-432-8470)			
		THE PHALL I	~~~ KI	THE PARTY OF THE P	11211511	CIMIN I I MINIT	L1/1J \	JUL 10- 01/0				
Stat	Of Data Slad (Month Day Your	ADIR, 20311 LA 32. Registrar's	Signature A	AD, DOOM	JO ONO 3	77,1117,27,110						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 70 . 2009 Month HILDA AUGUST. 02.15 AM MALIE STIFFIER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death AIR EL HARFORD UPPER CHESAPEAKE MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year) Feb. 7, 1939 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Hours Min. 1 □ M 2 🗓 F Months Days 213-36-8723 70 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2X No Harford Jarrettsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3232 Rocks Chrome Hill Rd. 21084 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify. Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herbert F. Tracey Sarah T. Freeland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra R. White, Daughter 3321 Blenheim Rd., Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 2, 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Wiseburg Cemetery White Hall, MD 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvige Licensee 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC (REAST disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Vear 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1) BE! VENOUS THROM BOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

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MD

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Exal. Investigate to multilised at once.

Maryland 21215-0036

Baltimore,

been signed by t should be detach funeral

requires that the death certificate be executed

the attending physician

certificate

After this

filled in by

Medical

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

68760

Vital

o

Division

17

DIr

Examine Physician/Medical þ Completed Be Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

> 24a. Was an autopsy 1 ☐ Yes 2 🖾 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
27. Manner of Death

investigation 2 Accident 6 Could not be determined 4 Homicide

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Malinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

3 Suicide

29a. Certifier

29c. License number 121778

1 🗲 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) An JWEAS

UNIER CHERASARG MODICAR CONTOR

State Registrar

32. Registrar's Signature 31. Date filed (Month. Day, Year)

170

		Plea	se Type or Pri					-	_	ible.	
	-	State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar								() () The mit ()	
		1. Decedent's Name (First, Middle, Last) 2. Date of						2. Date of Dea	ath	w w	3. Time of Death
Physicia /Medic		Mary Ella Timps	son					August	17, 200)9 ^{Year}	3:58 P M
Examine		4a. Facility Name (If not institution Kline Hospice l		4b. City, Town, or Location of Death Mount Airy			4c. County of Death Frederick				
Funeral Director		5. Social Security Number 212-38-8512	6. Sex 7. Ag	e (In yrs. la 79	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bird (Month, Da Dec. 1	th Year) 5, 1929	Coun	place (State or Foreign otry) Land
		Usual Residence of Decedent						Dec. 1.	J, 1725		1-1-1-1
ryland show		10a. State 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
he Ma	Director	Maryland Frederick			Frederick				10g. Citizen of	What Cour	41
with t	ä	10e. Street and Number			10f. Zip Code						
death	Funeral	1757 Carriage	12. Was Decedent	Ever in U.S	S. 13. \	21702 3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		Specify Yes or No		United States 14. Race - American Indian,	
after or ite	F	1 Never Married 2 Mar	Armed Forces? ried 1 □Yes 2 □ If Yes, Give	No		if Yes, speaty Cuba 1 □Yes 2😾 No	to Rican, etc.)		ack, White, e		
ural",	d by	3xxWidowed 4 LI Divorced Year or Dates:							Specify: Black		
n 72 h	Sete	(Specify only highest grade completed)			(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo	rking	16b. Kind of Business/Industry		dustry
d withing giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)			House	ekeeper		Home Maintenan			enance
e filectal Hy	Be	17. Father's Name (First, Middle,						me (First, Middle,		me)	
ould b Ment larked natic e	၉	Melvin Louis A						izabeth			
d 2 sh th and 7 is rr traum		19a. Informant's Name/Relations				ng Address (Street					Code)
tem 2		Anna M. Quinn 20a. Method of Disposition	/ Daughter	20b. P		Carriage		Date 20,	20c. Location		wn, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be redfried at once.		1 XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Me	Resi Resi	esition (Name of matory or other place thaven L Gardens	Aug	009	Freder	ick. N	Maryland
rmit. porta y Inju		21. Signature of Funeral Service		1 234		2. Name and Addre					
89 = 29		1//	7/_		9.	501 Catoc	tin Mtn.	Hwy. Fr	rederic		21701
Physician		23a. Part LEnter the disease, or second, or heart failure. List Immediate Cause (Final	r complications that cause t only one cause on each li	the death ne.	n. Do not ent	ter the mode of dyir	ng, such as cardia	c or respiratory a	irrest,	four	Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequ	uence of):	1 1	100	Cocc			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events b. Due to (or as a consequence of): C										
Due to (or as a consequence of):											
rtificat ng phy as th	Medi	IE EEMALE.									
d d d d d d d d d d d d d d d d d d d								ate of delivery onth Day Year			
the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant a	at time of d	eath 5L	Other (specify) _					
s that ined by detail	by Ph	Part II. Other significant conditi	ions contributing to death t	out not resu	ulting in the u	nderlying cause giv	en in Part	23e. Did 1	tobacco use co	ntribute to t	he cause of death?
equire een sig oufd b	ted b	Hype	teman	race	elli	5 10	Yes 2No	2 No 3 Probably 4 Unknown			
has be	Completed							24a. Was auto	psy	prior to co	ppsy findings available impletion of cause of
r: The								1 □Yes	2 No	death? 1 ☐ Yes	2000
siciar s certil	D Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☒ No	Hospital:	ent 2 🗆	EB/Outnatie	nt 3 DOA Oth		eath <i>(Check only o</i> Home 5 Resi		ther (Speci	Hospice
ig Phy ter this neral d	Ü.	27. Manner of Death	28a. Date of Inj		28b. Time o			T	how injury occu		mouse
endin sath. or: Af	atio	ZUACCIdent	igation			M 1□	Yes 2□No				
al or Att after d I Direct d in by	Certification: To	3 Suicide 6 Could 4 Homicide detern		ury - At ho c. (Specify	ome, farm, str //	reet, factory, office			Street and Nur wn, State)	nber or Rura	al Route Number,
ie Hospita 24 hours ie Funera detely fille	edical C	29a. Certifier (Check only one) 15d Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To th Within To th	Me	29b. Signature and title of certific	ddill	0.		29c. Licens	se number S945	8	29d. Date sign	ned (Month,	Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - South a Work word of 100 Bouch mon's 1 51201 21702									
Stat Registra	ALID 2.11 / USI 1 / Rest 1 / Jakoba 1										
					- /						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 18, AUGUST 2009 7:20 P BETTY JANE VAUGHT /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 8. Date of Birth (Month, Day, Yea Aug. 2, 1 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 😾 F 1925 Maryland 215-20-8903 84 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Evaluation in the hostified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County X Yes 2 No Directo Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21702 1900 Rosemont Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 □Yes 2**X**No If Yes, Give 1 Never Married 2 Married Specify: White 1 □ Yes 2 □ No Specify Completed by 3 Widowed 4 Divorced Year or Dates: 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maude Watkins Edgar W. Davis, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Davis - Daughter 14846 Sabillasville Road, Thurmont, Maryland 21788 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition permit. Pages 1 Department of h Important: If ite any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery Aug. 21, 2009 4 Donation 5 ☐ Other (Specify) Frederick, Maryland 22 Name and Address of Facility 21. Signature of Fur eral Service icenses Molesworth-Williams P.A., Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart. List only one cause in each line. 20872 Approximate Interval Between Onset and Death Immediate Cause (Final Physician /Medical resulting in death) e to (or as a consequence of): **Examiner** Sequentially list conditions. Due to (or as a consequence of) ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-tran Due to (or as a consequence of): physician s the burial Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 13 months? Year Month Day 5 Other (specify) signed by the a 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform page 2 certificate 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To funeral 28a Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of After 1 Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my online. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After

Baltimore, Maryland 21215-0036

State Registrar

Robert L. Kaufmann M.D. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed

29b. Signature and title

32. Registrar's Signature

and manner stated.

ause of death (Item 23a) (Type, Print)

29c. License number

300 West 9th Street, Frederick, Maryland 21701

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Aug 29, 2009 **Physician** 6:10PM ^M VanMeter-Bennett Virginia Demaris /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland 251 East Elder Street 9. Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Ye Aug 21, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 □ F 1930 79 220-40-1404 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10h County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expiritive 1, ust he healthand once. 1 ⊈Yes 2 ☐ No Cumberland MD Allegany Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 251 East Elder Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify. Specify: 2 white 3 → Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) hospital nursing assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Chaney Bishop Clinton Bishop ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) MD 21502 17 Pennsylvania Avenue Cumberland daughter Nancy Dolly 20b. Place of Disposition (Name of cemetery, crematory or other place)

Davis Memorial Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/1/2009 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ Wo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐Yes 2 ☐ No 2 **I**N 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ho 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0664167 eus rain mi

Registrar

DHMH 17 Rev 1/200

State

31. Date filed (Month, Day

SOO MEMORIAL AVE CUMBERUM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For Amend Items 25,27,28a-P per me, 895,09/24/09d Certificate of Death	and Mental Hyo	giene Reg. No. 11 11 11 12 12 13 14 15 17 18					
			Decedent's Name (First, Middle, Last)	2. Date of Dea	ath 3. Time of Death					
	Physicia	an	DORIS S WATSON	AUGUST	Day Year 18:05 AM					
-	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of		4c. County of Death					
	Examin	er			FREDERICK					
**	Funeral		FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under		h 9. Birthplace (State or Foreign					
	Director		059-12-2549 1 M 2 F 89 Yrs. Months Days Hours	Min. (Month, Day	y, Year) Country) 1919 Canada					
			Usual Residence of Decedent							
	yland		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits					
	a-fs	Director	Maryland Frederick Frederick		1 ∏Yes 2 ☐ No					
	or 28	ire	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?					
	th wil		801-F Stratford Way 21701							
	deal	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ori	rigin? (Specify Yes or No-	14. Race - American Indian, Black, White, etc.					
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	and 3		Lawrence M. Watson / Husband 801-F Stratford Wa	ay, Frederic	20c. Location - City or Town, State					
9	Pages 1 ar nent of Hea int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City of Town, State					
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Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funery Pervice Licens ROBERT E. DAILI	ity EY & SON FUN	NERAL HOMES, P.A.					
	90 = 40		Capalla Valley VIZOI NORTH MARK	KET STREET,	FREDERICK, MD 21701					
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		ü	27. Manner of Death 28d. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work?	tripped	how injury occurred Subject on step and fell.					
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	5 4 × 5				SIIAI OF					
			Mague (D16428		011109					
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1					
			Casper E. Cline, III, 300 West 9th Street, Freder	ick, MD 2170	01					
	Sta Registr		31. Date filed (Month, Day, Year) AUG 19 2009 32. Registrar's Signature							
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Formation	3. Time of Death 13:05 M				1. Decedent's Name (First, Middle, La.	an	Physicia	
Funded F			4b. City, Town, or					-
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District	Montgomery 9. Birthplace (State or Foreign Country)	If Under 24 Hrs. 8 Date of Birth	rs. last birthday) If Under 1 Year	Sex 7. Age (In yrs. I	5. Social Security Number 6. S		Funeral	
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Part of the part o		y at k? 28d. Describe how in	28b. Time of linjury 28c. Injury Wor	28a. Date of Injury (Month, Day, Year)	27. Manner eath 1 fatural 5 Pending	on: To	After this uneral di	_ E
29a. Certifier (Check only one) 29a. Signature and title of certifier one) 29b. Signature and title of certifier one 29b. Signature and title of certifier one 29c. License number one 29d. Date signed (Month one)	and Number or Rural Route Number, late)	28f. Location (Stree	at home, farm, street, factory, office	be 28e. Place of Injury - At ho	3 Suicide 6 Could not b	ertificati	after death Director: / I in by the f	Divisio
00060103	e(s) and manner as stated. and place, and due to the cause(s)	me, date and place, and due to the caus opinion, death occurred at the time, date	knowledge, death occurred at the ti nination and/or investigation, in my	aminer: On the basis of examina	(Check only 2 Medical Exa		24 hours e Funeral letely filled	Hospita
	Date signed (Month, Day, Year)			EL, MD	29b. Signature and title of certifier	Me	withir. To the	To the
1 01 01111-11 1 31 311111 17 7 700					/2 -		3	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar ALIC 2. A 2009		1110001 110	ignature	, . ,	31. Date filed (Month, Day, Year)	ate	Sta	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar/Amend#23a.Prt1.PerPhys.PCCcr Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) August 2009 Williams **Physician** Virginia Dare 3:54AM /Medical 4b. City, Town, or Location of Death **Lanham** 4c. County of Death \mathbf{PG} 4a. Facility Name (If not institution, give street and number) Doctor's Hospital **Examiner** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02–23–1923 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🛛 F 86 Yrs 214-28-4660 North Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Medical Examination in 18 to multiped an once. 10a. State Yes 2 No PG District Heights MD Director 10f. Zip Code 20747 10g. Citizen of What Country? 10e. Street and Number USA 7018 Nimitz Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 3 Widowed 4 Divorced Black 1 ☐ Yes 2 ☐ No Specify: Be Completed by 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Private Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Poteet Jane Mary Samuel Lindsay ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7018 Nimitz Dr. District Heights, MD 20747 19a. Informant's Name/Relationship (Type. Print) Theresa Lamont/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Pk 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-28-09 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRonald Taylor II FH 21. Signature of Fineral Service Licensee 10583 Middleport Ln. White Plains, MD 20695 andel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Aspiration Pneumonia 17 943 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for se a consequence of The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Box 68760, physician attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day 5 ☐ Other (specify) o been signed by the should be detached 9 | Unknown 9 Unknown ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à Obstruc. 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s autopsy certificate 2 No 1 ☐ Yes the Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1- Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident I Director: d in by the f 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

31. Date filed (Month, Day,

29b. Signature and title of certifier

elle 32. Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 9500

29c. License number

AMAPOLIS

2

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 8:55 P M 18, 2009 Zo1a Anita August Butler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Summerville Assisted Living Potomac 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Country)

August 21,1929 New Jersey If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, Days Months 1 □ M 24030 79 096-20-3941 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☐ No Director MD Montgomery Potomac 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20854 U.S.A. 11215 Seven Locks Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2 Yes, Give 1 ☐ Never Married 2 ☑ Married 2 KNO 1 ☐ Yes 2 🛣 No Specify þ Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Butler Fanny Cohen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7613 Fontaine Street, Potomac, Maryland 20854 Herbert Zola/ Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Garden of Remembrance Memorial Park 08/20/2009 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Clarksburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Fun and Service Licensee 1091 Rockville Pike, Rockville, Maryland 20852 MO1255 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Dementia Due to (or as a consequence of): Lung Mass Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Coronary Artery Disease that initiated events

Physician /Medical Examiner

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traunonce.

Funeral

Director

the

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72 hours after

d 2 should be filed within ; th and Mental Hygiene. 7 is marked other than "r

Saltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminar must be notified at

To the Hospital or Attending Physician: The law requires that the death certificate be executed within the Johurs after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Physician/Medical	
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Medical

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Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 21

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

resulting in death) Last	Due to (or as a consequence of): Hyperlipidemia	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ②□ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No
25. Was case referred to medical	26. Place of Death (Cl	heck only one)
examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		Location (Street and Number or Rural Route Number, City or Town, State)
	/sician: To the best of my knowledge, death occurred at the time, date and place, and iner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 3.X Certifying Nurse Practice	at the time, date and place, and due to the cause(s)

29c. License number

R096053

29d. Date signed (Month, Day, Year)

August 19, 2009

DHMH 17 Rev 1/2001

Babette Pennay, RN 11215 Seven Locks Rd, Potomac, Maryland

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year AUSTIN 1156 AM **Physician** September 06 roderick 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Bonsewur HOSPITA 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2□F 215-78-8705 Yrs 07/20/1960 MARVIAND Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show nt of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, its invited Examination and its another as 1 Yes 2 □ No Funeral Director BALTIMORE MD. 10g. Citizen of What Country? 10e. Street and Number U.S.A. GILMOR 2/217 1000 NORTH 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK Be Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ESSKAY OPERATOR MACHINE 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HENRY AUSTIN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 19a. Informant's Name/Relationship (Type. P Street BALTIMORE, MARY IAND PEARL BURIARK MOSHER MOTHER Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09 15 2009 LANDS DOWNE, M.D. Department or Important: If i any injury or once. 22. Name and Address of Facility Re DERRICK C. JONES FIH, P.A. nature of Funeral Service Lo PARK HGTS. AUE, BALTIMORE, MD 21215 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** C 0 disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physiclan; The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1NO 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1-Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

License number

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Saltimore. Maryland 21215-0036

P.O. Box 68760,

Records.

Division of Vital

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Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of	Maryland /		ertment of H Tificate of I				giene Reg. No.	2009	28580
			1. Decedent's Name (First, Middle, Las	st)					2.	Date of Dea		Veer	3. Time of Death
	Physici /Medic		Rose Marie Abb	ott					S	Month eptemb	er	4, 2009	11:45 P ^M
-	Examin		4a. Facility Name (If not institution, give	e street and numb	per)		4b. City, Town, or	r Location			$\overline{}$	County of Deat	h
			Casey House				Rockv				1	Montgome	
	Funeral Director		5. Social Security Number 6. S 219-86-3752	ex	. Age (<i>In yr</i> s. <i>last i</i>	birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	. Date of Birtl (Month, Day uly 19	(, Year)	Co	hplace (State or Foreign untry) aryland
	р >		Usual Residence of Decedent 10a, State 10b, County		10c. City, To	wn or Lo	ontion						10d. Inside City Limits
	aryla shov	'n	,										1 □ Yes 2 No
	he M 28a-f otifie	Director	Maryland Montgon	nery	Bı	cooke	eville				10a Citi	izen of What Co	
	with a or			1				833			rog. om	USA	
	eath rs 23 musi	era	3701 Damascus Road	12. Was Deced	ent Ever in U.S.	13.			rigin? (Speci	fy Yes or No-		14. Race - Ame	rican Indian,
36	be filed within 72 hours after death with the Maryland that Hyglene. d other than "natural", or items 23a or 28a-f show event, if a l'edical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Forc 1 ☐ Yes 2 If Yes, Give Year or Date	es? No		Vas Decedent of H fYes, specify Cuba 1 □Yes 21√2No	Specify		cán, etc.)		Black, White	
Baltimore, Maryland 21215-0036	2 hou atura	Completed	15. Decedent's Ed	lucation	16		dent's Usual Occup		est of wordsing		16b. Ki	ind of Business/	Industry
218	hin 7. e. aan "n	e e	(Specify only highest gra	ae compietea) College (1-4	or 5+)	'life. I	kind of work done of DO NOT use retired	during mo d)	ist of working				
2	filed withii Hygiene. other than	ပ္ပ	Elementary/Secondary (0-12)		, in the second	Ch:	ild Care					nunity (College
nd	hould be filed within of Mental Hygiene. marked other than matic event, Iral Mental Matic event, Iral Mental Menta	Be	17. Father's Name (First, Middle, Last)						ner's Name (f			Surname)	
<u>Y</u>	12 should be f h and Mental I 7 is marked of traumatic eve	မ	Unk.						ella M				
Mar	12 s h ar n is		19a. Informant's Name/Relationship (ng Address (Street						Zip Code)
e,	s 1 and 2 and 4 to the solution of Health a item 27 is rother train		Thomas B. Hamm, U	ncle			Boundary sition (Name of		ue nan			cation - City or	Town, State
2	ages int of it: If it		1 X Burial 2 ☐ Cremation 3 ☐		ate		sition (Name of natory or other place	i					
Ħ	nit. Partme		4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer		Good	22	nd Cemeters Name and Addre	ss of Faci	09/09			COLL CI	ty, Maryland
Ba	permit. Pages 1 and Department of Healt Important: If item 27 any injury or other it		1 (Thomas)	Inoma	s Gregor	M	acNabb Ei	mera	I Home	Atons	, 7111	e. Marv	land 21228_
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cau	sed the death. D							c, rary	Approximate Interval Between
-	Physician		Immediate Cause (Final		n Cancer								Onset and Death
	/Medical		disease or condition resulting in death)	a	r as a consequence								
and the same	Examiner		Sequentially list conditions	b									
	p ti	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a consequent	ce of):							
	icate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	r as a consequenc	o of):							
8760,	be ey ician burial	a E		Due to (or	as a consequent	e orj.							
387	icate phys s the	dical	•	d									
O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♠ No 9 □ Unknown	1 Live bir	ome of pregnancy th 2 Fetal deant ant at time of death	ath 3[Ectopic pregnanc Other (specify)	;y				23d. Date of de Month	livery Day Year
σ.	res that t signed by be detac		Part II. Other significant conditions of	ontributing to dea	th but not resulting	g in the u	nderlying cause giv	en in Part	H.	23e. Did to	obacco u	use contribute to	the cause of death?
of Vital Records,	uires n sign ld be	d by								1 🗆 ነ	es 2	□No 3□P	robably 4 💢 Unknown
00	w requir s been si should I	Completed								24a. Was	an	24b. Were a	utopsy findings available
Re	The lar	ᇤ						•		autop perfo	rmed? 2 M No	prior to	completion of cause of
ta		Be C	25. Was case referred to medical					26. Plac	ce of Death (1 Lives	s 2□No
<u> </u>	Physician: r this certific ral director, I	To B	examiner? 1 ☐ Yes 2 🕻 No	Hospital:	patient 2 ER/	Outpatie	nt 3 DOA Oth					6 COther (Spe	ecify)Hospice
0	ding Ph h. After th funeral	T:U	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of	Injury 28I Day, Year)	b. Time o Injury	f 28c. Injur Wor			d. Describe h			
io	endin ath. or: Af he fur	atic	2 ☐ Accident investigation	1			M 1 🗆	Yes 2	□No				
Division	r Atter de irecte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place o building	f Injury - At home, g, etc. (Specify)	farm, str	eet, factory, office		28	f. Location (5 City or Tov			ural Route Number,
	pital or Atten burs after deat eral Director: filled in by the												
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier (Check only one) 1		sis of examination		h occurred at the ti vestigation, in my o						
_	To t To t	Σ	29b. Signature and title of certifier J. Kerucut	Porce	mD		29c. Licens D 63					ite signed (Mon	
			V. Relicer		1		D 63	14	0		Sep	tember	5, 2009
	nv		30. Name and address of person who						MT OC	NOEE			
	7				Ster Mil Vistrar's Signature		ad Rockvi	ııre,	MD ZC	CCO			
	Sta Registr		SEP 09				backs						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1.	For State	e of Maryland / Departr	ment of Health and Micate of Death	1.		28581
1.	Registrar Decedent's Name (First, Middle, Last)			2. Date of Death	o .	3. Time of Death
Physician /Medical	myrtle	Bank	S	Sept 6	2009	5:36pm
	a. Facility Name (If not institution give street as	- 1 /	. City, Town, or Location of Death	40	c. County of Death	1
Funeral 5.	Social Security Number 6. Sex	7. Age (In yrs. last birthday) If	Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthpla	ce (State or Foreign
Director	215-54-2268 10M 25	F 58 Yrs. Mc	onths Days Hours Min.	Aug 6,19	5/ mai	. //
- P = 10	sual Residence of Decedent 0a. State 10b. County	10c. City, Town or Location	on ,	V	100	d. Inside City Limits
a-f sh	ma. N/A	7 Bal	truore			1 Xes 2 □ No
Site of the Market of the Mark	Oe. Street and Number Schw	artz Are 1	0f. Zip Code 2/2/2	10g. C	itizen of What Countr	y? •)
030 030 030 030 030	1 Never Married 2 Married 1 If Ye	Yes 2 No	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto i Yes 22 No Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, et Specify:	
	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Coll	eted) (Give kind	s Usual Occupation I of work done during most of workii NOT use retired)		And of Business/Indu	. /
d 21	7. Father's Name (First, Middle, Last)	NA	7 1 3 0 1	(First, Middle, Maide	n Sumame)	
Vland Vland Mental H mrked ott	James Gu	y SR.	Helen	Jac	Kson	
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiere. Important: If Item 27 1s marked other than any injury or other traumatic event, Item once. To Be Comp	9a. Informant's Name/Relationship (Type, Prin An toinette Jac	Ksan 403	ddress (Street and Number or Rura Schwartz;	I Route Number, City Ave La	or Town, State, Zip C	212/2
Ages 1 a sign of the control of the	0a. Method of Disposition 1 ☐ Burial 25 Cremation 3 ☐ Removal	20b. Place of Dispositio cemetery, cremato	ry or other place)	ate 20c.	ocation - City or Tow	n, State
Baltimore, permit. Pages 1 a Department of Her Important: If Item any injury or othe sonce.	4 Donation 5 Other (Special) 1. Signature of Funeral Service Lift nee) /22. Na	me and Address of acility 27	O Fredt	TILTON P	ass
10 <u>—210</u> ———————————————————————————————————	23a. Part1. Enter the disease, or complications	that caused the death. Do not enter th	ry P. Warch F	r respiratory arrest.	To. mg-	2/229 Approximate
Dispusion III	shock, or heart failure. List only one caus mmediate Cause (Final disease or condition	e on each line. Muocardie	1 Inte	ac tion		Approximate Interval Between Onset and Death
/Medical Examiner	esulting in death)	ue to (or as a consequence of):	x / 7),		
9	Sequentially list conditions, and b. D.	ue to (or as a consequence of)	prtery 1	115605	ie .	
executed in and ial-transit	Cause (Disease or injury hat initiated events C.					
8760, Action of cate be executed by sician and the burial-transit dical Examir	esulting in death) Last D	ue to (or as a consequence of):				
6876(fificate be globysicity is the bu	d					
	in the past 12 months?		opic pregnancy her (specify)		23d. Date of deliver Month	y Day Year
S, P. es that igned by be deta	art II. Other significant conditions contributing	g to death but not resulting in the under	lying cause given in Part I.	23e. Did tobacco	use contribute to the	cause of death?
ord:				1 Yes	2 □ No 3 □ Proba	bly 4 Unknown
Division of Vital Records, to Attending Physician: The law requirest after death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by				24a. Was an autopsy performed?	death?	sy findings available pletion of cause of
Vita iclan: Sertific ector,	25. Was case referred to medicaf examiner? Hospitaf		26. Place of Death			
Of \Physical Physical	1 163 25 140	1 ☐ Inpatient 2 ☐ ER/Outpatient ; Date of Injury (Month, Day Year) 28b. Time of Injury	3 DOA Cther: 4 Nursing Hol 28c. Injury at Work?	me 5 Residence 28d. Describe how in		
ion ath. r: Afte te fune	2 Accident investigation		Work? M 1 ☐ Yes 2 ☐ No			
Division c tal or Attending P is after death. al Director: After ed in by the funer Certification:	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural te)	Route Number,
	(Check only 2 Medical Examiner: On	To the best of my knowledge, death oc the basis of examination and/or invest I manner stated.				
To the within To the comp	29b. Signature and title of certifier	Sum	29c. License number	o Se	eate signed (Month, D	2009
3	0. Name and address of person who complete	d cause of death (ftem 23a) (Type, Prin	11/2/201	D .	04:	141) 2
State ³	31. Date fifed (Month, Day, Year)	32. Registrar's Signature	· LOCK FOR	my Da	1/move	1010 21230
Registrar	SEP 0.9.2009	July A. back	1			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Sept Year Physician 0750 AM 2009 Daniel G. Bates /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOSPITAL Bathmor St. Agnes n/a If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 M 2 □ F 219-30-5183 9/4/1934 Director 75 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo MD Anne Arundel Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5221 Kramme Avenue 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Marital Status Black, White, etc. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Completed by Specify. White 3 ☐ Widowed 4 🎇 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Carpenter Commerical Const. and Mental Hygi is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othn any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Daniel Bates Edell Huff ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Ebelein / Daughter 5221 Kramme Avenue, Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 9/11/2009 | Crownsville, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signatul of Funeral Service License 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** BLASGER CAIYCE (2 METASTATIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of): attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, 2 OBSTRUCTIVE PULMONUM 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Vital 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1∐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Division of this 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident irector: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours
To the Funeral 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of

ers in who compiled cause of death (Item 23a) (Type (Item) 23a) (T

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month Decedent's Name (First, Middle, Last) 3. Time of Death Day Year 0705PM 09 2009 03 F. Baker Sr. Duane 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A Union Memorial Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Min. | March | 27,1939 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 216-34-0758 70 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 XNo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 4 Vista Mobile Drive 21222 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: 3℃Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 years Truck Driver Crown Cork & Seal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gilbert Lee Baker Frances Rhelia Talbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Steven Baker 202 Ellerslie Court, Abingdon, Maryland son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Baltimore, Maryland 8, 2009 4 Donation 5 Dother (Specify) Connelly Funeral Home of Dundalk, P.A. Signature of 7110 Sollers Point Road, Dundalk, Maryland 21222 /art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme Title Cause (Final Schemic cardiomyopathi unknown disease or condition resulting in death) Due to (or as a consequence of): enal Cell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 4 hours Hemmonhag Due to (or as a consequence of): IF FEMALE

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

23a or 28a-f show

Director

Funeral

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Completed

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event, the Medical Examiner must be notified at

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permit. Pages 1 and 2 s
Department of Health as
Important; If Item 27 is
any Injury or other trau

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

P.0.

Division of Vital Records.

Examiner Physician/Medical Be Completed by Medical Certification: To

23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
		24a. Was an autopsy findings available prior to completion of cause of death? 1 \(\subseteq Yes \) 2 \(\subseteq No \) No
25. Was case referred to medical	26. Place of Dea	ith (Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 papatient 2 ER/Outpatient 3 DOA Other: 4 Nursing F	lome 5 Residence 6 Other (Specify)
27. Mann Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
	hysician: To the best of my knowledge, death occurred at the time, date and place miner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place miner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place miner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place miner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place miner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place miner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place miner; On the basis of examination and/or investigation, in my opinion, death occurred at the time.	

29c. License number

A72438946

LEMON MEMORIA HOSPITAL, BATTINGLE, MD

29d. Date signed (Month, Day, Year)

09,03,2009

State Registrar 31. Date filed (Month, Day, Year)

KOM

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROM KUATLASC (M.D. UMON M. 32. Registrar's Signature

and manner stated.

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dan	iel Michael I		n 1- For State	Sta	ate of Mar	yland /		tment of <i>ificate of</i>			Menta	al Hyg		Na	201	10 28	5.5
	Physici		Registrar 1. Decedent's Name	(First, Middl	e.Last)				Dean	<u> </u>		2.	Date of Dea		5 6	3. Time of Death	
Me	dical Exam	·	Daniel	(Micha	el		Bar	ron			Month Septembe	Day er 6, 2009	Year 9	0110 hrs	
			4a. Facility Name (if	not institutio					b. City, To	own, or L	ocation of	Death			unty of Death		
			3502 Dunha	ven Road					Dunda						more Cou	-	
	Funeral		5. Social Security No.		6. Sex	7. Age	(In yrs. las	st birthday)	If Unde		If Under	Min.			Co	thplace (State or Fountry)	oreign
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457	ırylan 8a-f sh at onc	cto	10e. Street and Nun						10f. Zip	Code				10g. Citizen	of What Cou	ntry?	
7	he Ma 1 or 22 iffed 3	Director	3502 Dunh	aven I	Road				2	1222				USA	A		
	death with the Maryland or items 23a or 28a-f show must be notified at once.	ral	11. Mantal Status		12. Was	Decedent E	ver in U.S	3. 13. Wa	s Deceder	nt of Hisp	anic Origi	in? (Spec	cify Yes or N	0- 14.	Race - Amer White, etc.	ican Indian, Black,	
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	d with	Completed	17. Father's Name (First, Middle	, Last)		1				8.Mother	s Name (I	First, Middle,	Maiden Sur			
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	MD nd 2 sho alth and m 27 is		Daniel M. 20a. Method of Dist		on Sr.	Fath		3502						Maryl	ation - City or	21222 r Town, State	
	of He		1 X Burial 2		n 3 Remo	val from Stat	te c	rematory or of	her place))	_	_	Date Ember				
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If litem 7: is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5				Var	Lawn					2009			aryland	
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0.00	/Medica		failure. List on Immediate Cause (ly one catuals	on each line.			xicati								Death	
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	of Vital Records, ing Physician: The law require the take certificate has been signed director, page 2 should be meral director, page 2 should be a sh	o Be	examiner?	2 No	Hospital:	I Inpatie	nt 2	ER/Outpatier	nt 3 🔲 I	DOA	Other ₄	Nursing	g Home 5	Residenc	e 6 🗸 Oth	er: Scene	
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	Division ospital or Attend hours after death ineral Director: of filled in by the	Certification:	4 Homicide			ecity)											
	Division of Vital Records, P.O. Box 68761 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier (Check only one)	Certifying I	Physician: To taminer:On the	ne best of my basis of exar	y knowled nination a	ge, death occ ind/or investig	urred at th ation, in m	ie time, di ny opinior	ate and pl n, death o	ace, and ccurred a	due to the ca t the time, da	ause(s) and i ate and place	manner as st e, and due to	ated. the cause(s)	
	To t To t	Medical	29b. Signature and	*	and ma	nner stated.					e number					nonth, Day, Year)	
		-	Call	20	HAI	Od i				O.C.	M.E.			Septe	ember 6, 2	2009	
			30. Name and add	ress of perso	on who complete	d cause of d	eath (Item	n 23a)									
			Carol Allan		ssistant Med			111 Penn	Street,	Baltim	ore, MI	2120	1				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Sen Day Year PAUL H. BROWN 5520A 4c. County of Dea 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE BALTIMORE COUNTY GENESIS- LOCH RAVEN 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year 1 ☑ M 2 ☐ F 215-28-0489 78 Mar. 29, 1931 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 ☐ Yes ŽŽNo Baltimore County Maryland Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21222 7842 Rockbourne Rd. 12. Was Decedent Ever in U.S. Armed Forces? X⊠Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) XXNever Married 2 ☐ Married 1 ☐ Yes XX No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ementary/Secondary (0-12) Night Watchman Baltimore City 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Moylan Walter Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 754 Towne Center Dr. Joppa., Md. Jane Sweeney (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Cem. 9-9-2009 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22 LassahAdre Tuheral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show ns 23a or 28a-f shov must be notified at

or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Examiner must any Injury or other traumatic event, the Medical Examiner must once.

Baltimore, Maryland 21215-0036

Director

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31. Date filed (Month, Day,

within 24 hours af To the Funeral D completely filled i Registrar

disease or condition resulting in death)	a. Due to (or as a consequence of):	ilune
Sequentially list conditions, many, searing to him edial cause. Enter Underlying Cause (Disease or Injury that initiated events	b. Due to (or as a consequence of):	
resulting in death) Last	C. Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反Unknown
		24a. Was an autopsy findings available prior to completion of cause of death? ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
25. Was case referred to medical	26. Place of Death (Che	eck only one)
examiner? 1 ☐ Yes 2 ₹ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5	5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ➢Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 □ Yes 2 □ No	Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	286. Place of injury - At nome, farm, street, factory, office 28f. Lo	ocation (Street and Number or Rural Route Number, ity or Town, State)
29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best of my knowledge, death occurred at the time, date and place, and di miner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.	ue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	1 HONO My War Days	29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

ess of person who completed cause of death tem 23a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3:05AM MARY E. BRENER 200 06 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HARFORD BELAIR, MARYLAND BEL AIR HEALTH AND REHABILITION CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug. | 21, 5. Social Security Number 7. Age (In yrs. last birthday) Year) 1931 9. Birthplace (State or Foreign **Funeral** Maryland 1 □ M 2/17F 219-28-6372 78 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 1 ☐ Yes 2013 No Director MD Anne Arundel Severn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7678 WB & A Road 21144 IIS Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White Specify: þ 3 Widowed 4XXDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mortimer Hester Mary Rowig ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (daughter) Sandra Leva 7678 WB & A Road, Severn, MD 20a. Method of Disposition 1 ☐ Burial 2 ★ remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Bayview Crematory 09/08/2009 Baltimore, MD 22. Name and Address of FacilitySchimunek Funeral Home of BelAir 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Payl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due from Gevebrolascula Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. cate has been signed by the a page 2 should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an this certificate Yes 2 E 140 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 | Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mayer of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural Injury 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

BPENER

certificate be

State Registrar

31. Date filed (Month, Day,

Medical

29a, Certifier

(Check only

29b. Signature and title of certifier

of death (Item 23a) (Type, Print) 30. Name and address of person

Year)

29d. Date signed (Month, Day, Year,

I 🖸 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 3,2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death more mewoog If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days 1. M 2□ F -50-2235 December 24 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Yes 2 □ No BATTIMORE 10e. Street and Number 10g. Citizen of What Country? 21206 U151H 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status Never Married 2☐ Married Specify: BIAC 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) medical Health. Elementary/Secondary (0-12) College (1-4or 5+) froblem Ott GKAde WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4ATTIE BA 1100, MI 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee THINERAL ITE. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final terebro work disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): ury

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than " any injury or other traumatic event, the Man

Physician

/Medical

Examiner

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Director

Funeral

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ed other than "natural", or items 23a or 28a-f shovevent, the Madical Examinar must be notified at

Baltimore, Maryland 21215-0036

Examiner Physician/Medical

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Certification: To Be

Medical

attending physician and for use as the burial-tran been signed by the should be detached cate has by page 2 s certificate After this of funeral dire within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

To the Hospital or Attending Physician:

Part II. Other significant cor
IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown
Cause (Disease or injury that initiated events resulting in death) Last

С	Due to (or as a consequence of):
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23c	. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy

23d. Date of delivery Month 5 ☐ Other (spec

art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
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9 Unknown

23e. Did tobacco use contribute to the cause of death?
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No

Year

25. Was case referre examiner? 1 ☐ Yes 2 ☑	Hospital:	1 Innetient 2	2 ☐ ER/Outpatient	2 🗆	DCA	Othor	/	th (Check only one) ome 5 ☐ Residence 6 ☐ Other (Specify)	
		I 🗀 ilipatierit 2	□ En/Outpatient	3 🗀	DUA	4	- Dannarsing H	ome b Hesidence b Littler (Specify)	
27. Mann of Death 1 V Natural 2 ☐ Accident	5 Pending investigation		Date of Injury (Month, Day, Year	28b. Time of Injury	M		Injury at Work? 1 □ Yes	2 🗆 No	28d. Describe how injury occurred
3 ☐ Sulcide 4 ☐ Homicide	6 Could not be determined	28e.	Place of Injury - A building, etc. (Spe	at home, farm, stree ecify)	t, facto	ory, off	ice		28f. Location (Street and Number or Rural Route Number City or Town, State)

L		_
29a, Certifier	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
(Check only	🖰 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ca	
one)	and manner stated.	

29b. Signature and title	of certifier Defoliation of the Control of the Cont
30. Name and address	of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D175

29d. Date signed (Month, Day, Year) 9-9-09

13 elli more MD 2/2/7

State

DARSHAN. 31. Date filed (Month, Day, Year) SEP 0 9 2009

1600 W. MO UNT Rayol Ave SALUI AMP 32. Registrar's Signature

Registrar

Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending p

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Iteme 23

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Baltimore, Maryland 21215-0036

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death

within 24 hours after death To the Funeral Director: completely filled in by the f

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27. Manner of Death 1 Natural 2 \ Accident 3 \ Suicide 4 \ Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	sician: To the best of my knowl ner: On the basis of examination and manner stated.	edge, death occurr in and/or investigat	ed at the time, date and place ion, in my opinion, death occu	e, and due to the cause(s urred at the time, date an	s) and manner as stated. d place, and due to the cause(s)						
29b. Signature and title of certifier			29c. License number	29d. Da	ate si ned (Month, Day, Year)						
Bel			D69540.		9809.						

813 Will nam woods Rel Suite 204 Parkville MD 21234

DHMH 17 Rev 1/2001

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SHAHJIGAR

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	To the Funeral Director. The Funeral Director. The funeral Director. The funeral Director of the funeral director of the director of the fundamental for the fundamental for the fundamental fundamental for the fundamental fundamental for the fundamental fu
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	214-30- Usual Residence		1 □ M 2 □ X F	77	rs.		4/14/193	32 MAF	RYLAND
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tor	MD	BALTI	MORE	ARE	BUTUS				1 □ Yes 2 □
Director	10e. Street and N	lumber			10f. Zip Code		10g	. Citizen of What C	Country?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 450 M Physician 28,2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Vursin ven wood et Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 219-90-4560 Yrs naryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "material may no other them." 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 1XYes 2 □ No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 126 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 □Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 00 K 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) aul ather 726 10, hew 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 □ Other (Specify) Funeral Service Licensee 22. Name and Address of Facility 2 21. Signatur 1 tome Approximate Interval Between Onset and Death disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, term disease, or complications that caused tr r hart failure. List only one cause on each line. Immedia Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and as the burial-trar Due to (or as a consequence of) Box 68760, IF FEMALE: ISA 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy detached for Day 5 ☐ Other (specify) P.O. ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ director, page 2 should be 2 🗌 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospital 24 hours a the Funeral to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only onel and manner stated. Within To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 00017202 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SATPALS BANG M.D. BALTIMORE MD ICIST HELENA AVE. 31. Date filed (Month, Day, Year) Registrar's Signal State

DHMH 17 Rev 1/2001

Registrar

SEP 0 9 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 20b perFH G895 9 16/09 WS
State of Maryland Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:34P M Delano 04 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Hutzlar me Baltin Pikesville Lane 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours MD 76√Yrs. Director Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show or other traumatic event, the Medical Exeminer must be notified at Ba Himore Pikesville 1 ☐ Yes 2 No MD Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Hutzlar Lane items 23a or 21208 1600 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced "natural" Be Completed 16b. Kind of Business/Industry Bowle State 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) be filed within College (1-4or 5+) S+ Years Elementary/Secondary (0-12) and Mental Hygiene. Universit votessor 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mills ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) me/Relationship (Type Print) permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is n any Injury or other traunonce. 703 Fanwood Court Forestville MD 20747 naviote Young 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pikesville, MD 1 ■Burial 2 □ Cremation 3 Removal from State Druid Ridge 4 Donation 5 Dother (Specify) Youghn C. Greene Funeralsycs 21. Signature of Funeral Service Licensee 22. wme and Address of Facility C. Gr Road Landalbtown ND 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a scardiac or respiratory arrest shock, or heart failure. List only one cause and line. Immediate Cause (Final 4ecc Physician ardiac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and the burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) detached 9 Unknown þ האוכו נוווא certificate has been signed! funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🗶 No 1 ☐ Yes 2 ☐ No Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation or Attending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 9 2 Registrar's Signatu State 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# 19b, perINF, 6895, 9/11/09, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) SEPT. 20**09** 5:45 A_M **Physician** MILDRED GERALDINE CHESTER /Medical 4c. County of Death
BALTIMORE 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner GLEN ARM GLEN MEADOWS Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Min. 1 □ M 2 🕏 F Months Days Hours 90 219-05-6708 MD APRIL 12,1919 **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director GLEN ARM MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21067 by Funeral 11630 GLEN ARM RD L14 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 ☐ No Maryland 21215-0036 WHITE Specify Specify: 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any fujury or other traumatic event, the Me any fujury or other traumatic event, the Me any Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING SECTION SUPERVISOR 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDNA IRENE BENSON RAYMOND A. GONCE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3208 RUECKEN AVE BALTIMORE, MD 21214 19a. Informant's Name/Relationship (Type. Print) 3208 RUECKEN AVE JOHN CHESTER-SON Rueckert Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD GARDENS OF FAITH 9/9/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC Signature of Funeral Service Licensee BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part . Enter the disease, or complications shock, or heart fail vol. List only one cause Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (First disease or condition resulting in death) dom **Physician** rencu /Medical to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. aftending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) signed by the a o 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) September 08, 2069 29b. Signature and title of certifie w 1)30433

Registrar
DHMH 17 Rev 1/2001

State

10V

N Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

31. Date filed (Month, Day,

6701

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G895, 9/15/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death SEPT. 2009 4:42 PM EILEEN FRANCES CONWAY 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE PARKVILLE 2800 UPRIDGE CT 8. Date of Birth (Month, Day, Year)
JULY 28,1926 If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 □ M 2 □ X Yrs. MD 83 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2800 UPRIDGE CT 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PAULINE UNKNOWN UNKNOWN HOFFMEYER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 516 KENORA DR MILLERSVILLE, MD 21108 19a. Informant's Name/Relationship (Type. Print) ELAINE HUBBARD-DAUGHTER 516 KENORA DR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 9/8/09 BALTIMORE, MD GARDENS OF FAITH 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC BALTIMORE, MD 21206 6415 BELAIR RD 23a. Part1. Enter the disease or shock, or heart failure. omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Immediate Cause (Final disease or condition resulting in death) COR REPORTED SIVE CARDIDUASCULA if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Due to (or as a consequence of): IF FFMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Aresidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner Division or Vital Records, P.O. Box 68760,

or Attending Physician: The law requires that the death certificate be executed and physician as 1 Jas certificate After this Director: / within 24 hours after To the Funeral Dire

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

items 23a

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23 ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must

permit. Pages:
Department of H
Important: If ite
any injury or ot
once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Examiner must be notified at

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by Funeral

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Completed

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Medical Certification:

29a, Certifier (Check only

31. Date filed (Month

with the Maryland

State

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of per

and manner stated

32. Registrar's Signature

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PULHOTR

8713 HAR park

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

^		-	State of Ma State of Ma State Registrar	-	oartment of H <i>ertificate of L</i>			iene _{eg. No.} 200	9 28594
	Dhuaisia		1. Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day Yea	3. Time of Death
	Physicia /Medic		George B. Chenowe	th		1 - 1 - 1 D - 1	August	31 2009 4c. County of D	
	Examin	er	4a. Facility Name (If not institution, give street and number) Carroll Hospital Center			Location of Death		Carr	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day April 8		Birthplace (State or Foreign Country)
	Director		217-01-0177 1X M 2□ F	89 Yrs.	Months Days	Hours Min.	April 8	, 1920	MD'
	w w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	Maryla -f sho	tor	MD Carroll	٤	Sykesville				1 □Yes 2 No
	n 198a	irec	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What	•
	23a c	Funeral Director	1124 Pouder Road			1784		US	
	er des items	nue	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent E Armed Forces? 1 □ T]Yes 2 □ N		 Was Decedent of His If Yes, specify Cuba 	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
336	irs aft	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N 1 ☐ Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates:	WWII	1 □Yes 2√∏No	Specify:		Specify:	White
21215-0036	72 hours after death with the Marylan "natural", or items 23a or 28a-f show deal Eron it her swat be selffed a	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. De	cedent's Usual Occupa	ation Juring most of worki	ing 1	16b. Kind of Busine	ss/Industry
2	/ithin /ithin hae.	mple	Elementary/Secondary (0-12) College (1-4or 5-	+) \\ \frac{\life}{\life}	ive kind of work done of e. DO NOT use retired Painter)		MD Transi	t Authority
2	filed within 72 hours after death with the Maryland Hyglene. other than "natural", or items 23a or 28a-f show ent, the Medical Eventing out be coulfied at	င္ပ	17. Father's Name (First, Middle, Last)			18. Mother's Name			
Maryland	be d d	To B	George Chenoweth			Eva Re	ote		
ary	0 00 00		19a. Informant's Name/Relationship (Type. Print)	I	ailing Address (Street				
<u>ر</u> ک	1 and 2 Health em 27 i		Mrs. Cecelia Ciampa (Daught		55 Cherry 7			20c. Location - City	
Baltimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		sposition (Name of trematory or other place Park Ceme	e) ;		Baltimore	
≣	permit. Pages Department of Important: If it any injury or o	- 33	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses	LEGITATIVE	22. Name and Addres	ss of Facility	- 1		, 112
ñ	Dep any any onc			400764	HAIGHT FUN PO Box 195	Svkesvi	11e. MD	21784	
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ne.	enter the mode of dyir	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physician	1	Immediate Cause (Final disease or condition a. My Consulting in death)	cardial]	Infarction				Chief and Boath
1	/Medical Examiner	er	Due to (or as a	a consequence of):	ant Discoss				
				conary nea	art Disease	2			
l	cuted nd ransit	Examiner	rary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause)						
, 0,	icate be executed physician and the burial-transit		resulting in death) Last Due to (or as	a consequence of):					
8760,	death certificate be executed e attending physician and d for use as the burial-transit	dical	d						
Box	eath certifi attending for use as		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		O Catania araspana			23d. Date of	
œ œ		Physician/M	in the past 12 months?		3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		Month	Day Year
<u>Р</u> .	at the ded by the etached	Phy	9 ☐ Unknown Part II. Other significant conditions contributing to death be	ut not resulting in th	e underlying cause giv	en in Part I	23e. Did to	bacco use contribu	te to the cause of death?
ds,	The law requires that the ate has been signed by th bage 2 should be detache	d by	Fait II. Other significant conditions contributing to death of	at not rooding in the	o undonying addoc gir		1 □ Y	es 2 No 3 □	Probably 4 Unknown
Records,	w requir s been s should	Completed					24a. Was a		e autopsy findings available
	The law te has age 2 s	dmo				~~~	autop perfor 1 □ Yes	med? deat	r to completion of cause of th? Yes 2 □ No
æ	hystcian : The la his certificate ha I director, page 2	BeC	25. Was case referred to medical examiner?			26. Place of Deat			
<u>></u>	Physician: r this certifica ral director, p		1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie	ent 2 ER/Outpa		4 LI Nursing Ho		lence 6 Other	Specify)
S C	ding F	ijon:	27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	ury 28b. Tim ly, Year) 1nju	ry Wor	yan k? Yes 2∐No	280. Describe ii	low injury occurred	
Division of Vital	or Attendi after death. Director: A	fica	3 Suicide 6 Could not be 28e. Place of Inju	ury - At home, farm.	street, factory, office		28f. Location (S		or Rural Route Number,
á	tal or A s after al Direct ed in by	Certification: To	4 Homicide determined building, etc.	c. (Specify)			Only of You	ni, State)	
3	the Hospital or Attending hin 24 hours after death. the Funeral Director: After mpletely filled in by the fune		29a. Certifier (Check only 2 Medical Examiner: On the basis of	of examination and/o	eath occurred at the ti or investigation, in my	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and mann date and place, and	er as stated. due to the cause(s)
f	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	one) and manner sta	леd.	29c. Licens	se number		29d. Date signed (M	Month, Day, Year)
	F ≯F ŏ		MANUM Y	~	DO	052454		Sept. 2	, 2009
			30. Name and address of person who completed cause of d	teath (Item 23a) (Ty	pe. Print)				1
			Linda M. Lang M.D	34		hns Lar	re Dui	4,61	LICOTT CITY
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registr	rar's Signature	Kel			/	FID AIDYA

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryland / De C	ertificate of			g. No. 2009	28595
ı	Physicia		Decedent's Name (First, Middle, Last) Edward	W.	Crusse		2. Date of Death Month September	Day 2009	3. Time of Death
-N.	/Medic Examin		4a. Facility Name (If not institution, give stre		4b. City, Town, o	r Location of Death		4c. County of Death	
ran .			Genesis Eldercare -	Heritage Center	Dund			Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 1 1 X N	7. Age (In yrs. last birthda 1 2□F 91 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 16,	Year) 9. Birthp Coun 1918 Mary	lace (State or Foreign try) Land
	w		Usual Residence of Decedent 10a, State 10b. County	10c. City, Town or	Location			11	0d. Inside City Limits
	f sho	ō	Maryland Baltimore		dalk				1 ☐ Yes 2 XNo
	the N 28a- notifi	Director	10e. Street and Number	Dan	10f. Zip Code		10	g. Citizen of What Coun	try?
	3a or st be		60 Kinship Road		2122	22		USA	
36	. Pages 1 and 2 should be filed within 72 hours after death with the Maryland iment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23a or 28a-f show lant: If item 27 is marked other than "natural", or other traumatic event, it is Modical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married	1 XYes 2 No If Yes, Give	3. Was Decedent of H If Yes, specify Cub 1 □Yes 2 🛣 No	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, 6 Specify: Whi	etc.
2-00	72 hours 'natural' dical Ex	eted b	3X Widowed 4 ☐ Divorced 15. Decedent's Educat (Specify only highest grade c	Year or Dates: ion 16a. De ompleted) (G	cedent's Usual Occu ive kind of work done e. DO NOT use retire	pation during most of work	1 ing 1	6b. Kind of Business/Inc	
2121	d within giene. er than "	Completed	Elementary/Secondary (0-12) 12 years	College (1-4or 5+)	e. DO NOT use retire lesman			Automotive	
Maryland 21215-0036	ild be file fenta! Hy rked oth	To Be (17. Father's Name (First, Middle, Last) William Crusse			18. Mother's Name Lillian		aiden Surname)	
Mary	1 and 2 should be filed w Health and Mental Hygien em 27 is marked o ther th other traumatic event, th	_	19a. Informant's Name/Relationship (Type Phyllis Frieze	· ·	ailing Address <i>(Street</i> Kinship Ro			City or Town, State, Zip and 21222	Code)
Baltimore,	Pages 1 a ment of Hea ant: If item ury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)		sposition (Name of rematory or other pla of Faith	Septe	incer.	Oc. Location - City or To	
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Fynedal Service Licensee	Conneller	22. Name and Addre Connelly F 7110 Solle	ess of Facility Funeral Ho ers Point	me Of Du Road, Du	ndalk,P.A. ndalk,Md. 2	21222
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death. Do not					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	METASTATI	C BONE	CAN	CER		Onset and Death
1	/Medical Examiner			Due to (or as a consequence of): LEREBROVA Due to (or as a consequence of):	Chin Al	2 NICA	EASE		
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyling Cause (Disease or injury that initiated events c	Due to (or as a consequence of):	SULLA	9100	7120		
	e cute c ind transii	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	DEMENTIA Due to (or as a consequence of):					
68760,	tificate be executed g physician and as the burial-transit		d d	HYPERTEN	SION				
289	ificate g phy as the	edical	u.,		01011				
O. Box	eath cer attendin for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown		3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of delive Month	ery Day Year
rds, P.	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contri	buting to death but not resulting in th	e underlying cause gi	ven in Part I,		acco use contribute to the	
Records,		Completed					24a. Was an autopsy perform 1 □ Yes 2	prior to co	psy findings available mpletion of cause of
Vita	ctor, p	Be C	25. Was case referred to medical examiner?			26. Place Deat	h (Check only one		
7	shysion this or al dire	ပ္	1 ☐ Yes 2 ☐ Mo	spital: 1 ☐ Inpatient 2 ☐ ER/Outpa	tient 3 DOA			nce 6 Other (Specia	(y)
ono	fe ne	tion:	27. Manne Death 1 atural 5 ☐ Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Tim Injur	y Wo	ry at rk?]Yes 2 □ No	28d. Describe how	v injury occurred	
Division of	2 4 4 5	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)			28f. Location (Str. City or Town,	eet and Number or Rura State)	al Route Number,
1	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical C		cian: To the best of my knowledge, d r: On the basis of examination and/o and manner stated.					
U	To th withir To th comp	Me	29b. Signature and title of certifier	1. 52004	29c. Licen	se number	29	d. Date signed (Month,	Day, Year)
			30. Name and address of person who com	pleted gause of death (Item 23a) (Ty	pe, Print)	21108	1	1-0-0	1
	Sta	te.	Sanda (U) 31. Date filed (Month, Day, Year)	ullu 2 Man 32. Registrar's Signature	11d- 410	ce Du	dalle	MI) 212	222
	Registr		SEP 0.9 %	100 Deneur S.	parked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** \bar{q}^{M} 11:58 Marcia Denise Cousins September 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner Anne Arundel Chesapeake Hospice House Linthincum If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 2 🖾 F 213-80-5189 Director September 23, 1958 Washington, D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r than "natural", or items 23a or 28a-f sho by Funeral Director 1 ☐Yes 2 ☐ No Maryland Prince Georges Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20708 13202 Miles Court Apartment 403 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 TNo Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Day Care Center ulth and Mental Hygir

27 is marked other

r traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Richard Cousins Geraldine Loretta Washington ျ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 1660 E. Belvedere Ave., Apt.207, Baltimore, MD 21239 Alicia M.Cousins/ Sister permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other once. or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) September 2. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 2009 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Foad, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □ Yes 2√No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 \sum Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) Hospice 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month Day, Year) September 03, 2009 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Ibon 23a) (Type, Print) Russell R. Deluca, M.D. 905 Hospital Dr., Glen Rumie, MD 21061

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

SEP 09 2009

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Margaret Nolan Dodson 31 2009 8:35a August /Medical 4c. County of Death Carrol1 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sykesville 6925 Stratford Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Mar 1 () | Mar 5. Social Security Number 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2**V**□ F 216-01-3270 0/

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Marical Experiment: ust be pruffled at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	210-01-3	219	Λ	94					Hai	10, 1.	713	TID
	Usual Residence of I	Decedent										
	10a. State	10b. County		10c. C	ity, Town	or Location						10d. Inside City Limits
ctor	MD	Car:	roll		Sykes	svill	е			1 □ Yes 2√□ No		
irec	10e. Street and Num	ber		10f. Zip Code 10g. Citizen of						ountry?		
al D	6925 Stratford Drive						21784	4			USA	
ıner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?					13. Was Dec	cedent of Hispan Decify Cuban, Me	ic Origin?	(Specify Ye	s or No-	14. Race - Am Black, Whi	
Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:							ecify:	orto riiodii,	510.,	Specify: W	
leted	(Specia		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					Kind of Business	3/Industry			
omb	Elementary/Secon	dary (0-12)	College	(1-4or 5+)		IIIC. DO 1401	Homemal	ker			Dom	estic
Se C	17. Father's Name (F	First, Middle, i	Last)				18. 1	Mother's N	ame (First,	Middle, Maide	en Surname)	
To E	Edwa	ard Gi	sse1					Ber	tha M	ae Trex	ler.	
100	19a. Informant's Nar	me/Relationsh	nip (Type. Print)	Daughte	r) ^{19b.}	Mailing Addre	ess (Street and N	lumber or i	Rural Route	Number, City	or Town, State,	Zip Code)
	Mrs. Marjo										MD 217	
	20a. Method of Dispo			20b.	Place of cemeter	Disposition (Λ y, crematory o	lame of r other place)		Date	20c.	Location - City or	r Town, State
	1 ☐ Burial 2 [X 4 ☐ Donation		3 □ Removal from pecify)	a State I			remation	9/2	2/2009) Sy	kesville	e, MD
	21. Signature of Fun	neral Service I	Licensee	+ 400T	T.U	HAIGI	and Address of I HT FUNER Ox 195 S	Facility PAL HO	OME &	CHAPEL	P.A.	
	23a. Part 1. Enter the	e disease, or	complications that	caused the dea							/ 04	Approximate
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition										Interval Between Onset and Death	
	resulting in death) Due to (or as a consequence of):											
ner	Sequentially list conditions, if any, leading to innecliate cause. Enter Underlying Cause (Disease or injury											
Cause. Enter Orderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
calE	Due to (or as a consequence of):											
edi												
mpleted by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	noriths?	tal death 31 Fetonic programmy						23d. Date of de Month	elivery Day Year		
P.	Part II. Other signific	cant conditio	ns contributing to	death but not res	sultina in	the underlying	a cause given in l	Part I.	23	e. Did tobacco	use contribute t	to the cause of death?
d by		,					,		_ _	1 ☐ Yes	2 □ No 3 □ F	Probably 4 Unknown
plete									24	a. Was an autopsy	24b. Were a	autopsy findings available o completion of cause of
Com									1.0	performed?]Yes 2.⊡⊀	death?	es 2 No
Be	25. Was case referre	ed to medical					26.	Place of D	eath (Chec			
	1 ☐ Yes 2 ☐ 1	No	Hospital: 1] Inpatient 2] ER/Out	patient 3	DOA Other: 4	☐ Nursing	Home 5	Residence	6 ☐Other (Sp.	ecify)
tion:	27. Manner of Death 1 Natural 2 □ Accident	5 ☐ Pending	g (Mo	e of Injury nth, Day, Year)	28b. T	ime of njury M	28c. Injury at Work? 1 □ Yes	2 □No	28d. De	scribe how inj	ury occurred	
tifica	3 Suicide	6 ☐ Could n determi	ot bo	e of Injury - At h	i nome, far ify)	m, street, facto	ory, office		28f. Loc	cation (Street a	and Number or F ite)	Rural Route Number,
Cer		_/_										
Medical Certification: To	29a. Certifier (Check only 2 one)	1 Certifyin 2 Medical I	g Physician: To the Examiner: On the and ma	ne best of my kn basis of examin nner stated.	owledge ation and	, death occurred/or investigati	ed at the time, da on, in my opinior	ate and pla n, death oc	ace, and du ccurred at th	e to the cause ne time, date a	(s) and manner and place, and du	as stated. ue to the cause(s)
M	29b. Signature and ti	itle of certifier	1.100			2	9c. License num	nber		29d. C	ate signed (Mon	nth, Day, Year)
	30. Name and addre	ss of person	who completed car	use of death (Ite	m 23a) (Type, Print)	1 608	1		200	151107	
	31. Date filed (Month	- TU	ery.	Scute / Registrar's Sign	102/	1000	Libalt	y RI	9 8	Less	& ill	21789
te ar			9 2009	Markara	A	back	lad .				<i>[</i>	

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 2132 PM MARIA ALMA ,2009 SEPTEMBEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SQUARE BALTIMORE BALTIMONE HUSPITAL RANKLIN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) 15, 1935 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2√□ F Italy 74 215-66-7130 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at Middle River Baltimore MD Director 1 ☐ Yes � ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21220 823 Maplecrest Drive filed within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☑ No Specify: Specify: Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College Fraternity Cook 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f ment of Health and Mental Maria Galesic Joavachino Stermotic ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any Injury or other trau 4 Overbrook Court-Bel Air, Maryland 21014 Philip Puntanen-son 20b. Place of Disposition (Name of cemetery, crematory of other place)

Evans Funeral Chapel and Cremation-Bel Air

Date

20c. Location - City or Town, State
Forest Hill, Maryland 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Service 8800 Harford Road-Parkville, Maryland 21234 andrae toold 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDIAL **Physician** INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 5 HITERY DISEASE ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ending physician and use as the burial-transit 3 C TOBACCO Due to (or as a consequence of): the attending physician and for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 No Vital 1 ☐ Yes or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 1 Inpatient o completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

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BALTIMORE, MD

be and address of person who completed cause of death (Item 23a) (Type, Print)

ERKIN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year p^{M} **Physician** 2009 Michael DeCheke September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 6 Ivy Bridge Court Reisterstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 70 1 ☑ M 2 □ F Hineary 027-62-2290 August 4, Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the tredict Exercition and the resultied at 1 ☐ Yes 2 No Director Maryland Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number United States 21136 6 Ivy Bridge Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2X No Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r College (1-4or 5+) 5+ Elementary/Secondary (0-12) Professor/Researcher College 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ilona Simon Paul Varju ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is rr any injury or other traum once. 6 Ivy Bridge Court Reisterstown, Maryland 21136 Annamaria DeCheke, Wife 20c. Location - City or Town, State 20a Method of Disposition Metro Crematory, Inc. September 8, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 21. Signature of Funeral Service Licens Alice 299 Frederick Road Baltimore, Maryland 21228 lser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Vr. CUVICEL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 1 □Yes 2 □No 4 ☐ Pregnant at time of death 5 Other (specify) 9 | Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has funeral director, page 2 s performe 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 5 Pending investigation 1 Natural after death.

I Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: To the Hospital within 24 hours a To the Funeral completely filled

72 hours after

Baltimore, Maryland 21215-0036

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cisebera 31. Date filed (Month, Day; Year)

29b. Signature and title of certifier

trar's Signature Cenus

and manner stated.

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29c. License number

St, Parl Phye

D40854

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year **Physician** 1:35 Edwards Siptember ames 03-2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Hospita N/A Secours If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 22 5. Social Security Number Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday **Funeral** , Year) 1959 1XM 2□ F Months Hours Davs Maryland 50 Yrs. June 213-78-1003 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Department of Health and Mental Hygiene. Internation items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than your internation of the traumatic event, the Medical Eventinal must be notified at once. 1 Nes 2 No Director N/A Baltimore Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 239 North Monroe Street 21223 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify. Specify: Black ģ 3 Widowed 4 Divorced 2 should be filed within 72 hours nand Mental Hygiene.

is marked other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Street Cleaner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Edwards Margaret B. Lee 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Margaret Edwards, Mother 1522 West Fayette Street Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metro Crematory Inc. 09/03/09 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. Thomas 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician metabolic hours disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) been signed by the a should be detached f 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ے، دہ کر مے، ح 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2601 24a. Was an page 2 s autopsy certificate 1 ☐ Yes 2 **3** Vo To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Dunpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

Registrar

31. Date filed (Month, Day, Year)

Simmons

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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Baltimore, MD

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			State Registrar		Cei	rtificate of	Death	2. Date of Dea	Reg. No.	I C	28601
	Physici	an	1. Decedent's Name (First, Middle Robert Gene El					09-02-		Year	3. Time of Death
- Sandy	/Medic Examin		4a. Facility Name (If not institution)	4b. City, Town, o	r Location of Death		4c. County	of Death	
	Examili	le:	Stella Maris H	_		Timon	ium		Bal	timor	e
	Funeral Director		5. Social Security Number 215-42-4247	6. Sex 1 X M 2 □ F	ge (In yrs. last birthday) 64 Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 03-08-	h Yea <i>r</i>) -1945	9. Birthp Coun	place (State or Foreign htty) MD
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
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	or 288	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	23a c	ra [2204 School Rd	i			21034			USA	
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Exervitivat most be redified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Mar 3 □ Widowed 4 □ Divorced	If Yes Give	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ሺ No	dispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - Americ .ck, White, e fy: Whi	etc.
21215-0036	be filed within 72 hours after death with the Marylan ttal Hygiene. ed other than "natural", or items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show event, if a Madical Extrator must be notified at	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed) College (1-4or	5+) (Give	DO NOT use retired	during most of worki d)	ng	16b. Kind of B		
121	filed wi Hygier other the		12 17. Father's Name (First, Middle,	(ant)	Stat	e Trooper	18. Mother's Name	/Firet Middle			aryland
Maryland		Be C	Wilton Ellis	Last)			Helen Ba			ne)	
ıry	d 2 should be th and Ments 7 is marked traumatic en	2	19a. Informant's Name/Relations	ship (Type. Print)	19b. Mailii	ng Address (Street	and Number or Rura	al Route Numbe	er, City or Town	, State, Zip	Code)
	2 E E		Linda Ellis (W	Vife)	2204	School 1	Rd Darling	gton, M	D 21034		
ore	. Pages 1 and ment of Healtl tant: If item 27 jury or other t		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2 Demoved from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place	ce)	Date	20c. Location	- City or To	wn, State
Ĕ	nit. Pag artment ortant: I injury o		4 □ Donation 5 □ Other (S		Darlingto	on Cemete	ry 09-05	-2009	Darlir	gton	, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service	Rhu	1	ne olu w	. MacPhal	ra be	r Alr,	Home MD 21	of BelAir 014
			23a. Part 1. Ente the disease, or shock, or heart failure. List	r complications that cause t only one cause on each	d the death. Do not entine.	ter the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
· Park	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a.	TE CANCER						
	Examiner		,	Due to (or as	s a consequence of):						
	1	je.	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to (or as	s a consequence of):						
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, 0,	De exe	1 - 1	resulting in death) Last	Due to (or as	s a consequence of):						
9289	cate t	dica		d						\rightarrow	
O. Box	The law requires that the death certificate be ate has been signed by the attending physicia agge 2 should be detached for use as the bur	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	су		1	ate of delive	ery Day Year
о, С	that ned by deta	by Ph	Part II. Other significant conditi	ions contributing to death	but not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco use cor	itribute to th	he cause of death?
rds	w requires t s been signe should be							1 🗆 '	Yes 2 No	3 ☐ Prot	bably 4 🗌 Unknown
Records,	law re as bed 2 sho	Completed						24a. Was			opsy findings available ompletion of cause of
Ä		E C						perfo 1 □ Yes	rmed?	death? 1 🗆 Yes	·
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:		oth	26. Place of Death	h (Check only c	ne)		
of	Attending Physrdeath. ector: After this by the funeral dir	ition: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date of In	ient 2 ER/Outpatie jury 28b. Time o ay, Year) Injury	f 28c. Inju	4 🗆 Nursing Ho	-	dence 6X1Ot		fy) HOSPICE
Division	i Çire	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 200. Flace of It	njury - At home, farm, str tc. (Specify)	reet, factory, office		28f. Location (; City or To		ber or Rura	al Route Number,
	Hospital 24 hours a Funeral (Medical ((Check only 2 Medical	ng Physician: To the bes	of examination and/or ir	th occurred at the tinvestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) and n date and place	nanner as s , and due t	stated. o the cause(s)
	To the within To the comple	Mec	one X Nurse Pra 29b. Signature and title of certifie	actitiomer ^{ners}	ilateu.	29c. Licens	se number		29d. Date sign	ed (Month,	Day, Year)
	F > F 0		> ASSAUR	DRANF		RKIC	1792		9/2/	200	7
	100		30. Name and address of person	who completed cause of	death (Item 23a) (Type,	Print)			- 11 1		
	Sta		JACKIE JONES, 31. Date filed (Month, Day, Year)	32. Regis	DULANEY VAI trar's Signature		TIMONIUM	MD 21	093		
	Registi		SEP 09 20	109 Senewa	1. par						
DH	MH 17 Rev 1/2	2001	OL: 0 - 20	100		BINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day **Physician** 4:46 A M 6, 2009 SEPT. ANDREW MARK FAZENBAKER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE DUNDALK 1904 OXLEY RD If Under 1 Year If Under 24 Hrs.

Wonths Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 ☐ F AUGUST 21,1968 41 213-04-3258 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or Items 29 or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. once. 1 ☐ Yes 2 ☐ No Director DUNDALK MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 1904 OXLEY RD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BALTIMORE CITY WATER METER INSTALLER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEONA FITZPATRICK WILLIAM FAZENBAKER II 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1904 OXLEY RD BALTIMORE, MD 21222 MICHELE FAZENBAKER-WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/10/09 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) SACRED HEART OF JESUS 21. Sign true of Funeral Service Licensee 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC 6224 EASTERN AVE BALTIMORE, MD 21224 23a. Part1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should, or heart failure destroitly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown pidemia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 😿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

and

certificate

death.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tollgate Rd Bel Armi 32 Bedistrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Reginald Thomas Ford, Sr. 12:15p M September 6, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Bowie 3800 Enfield Chase Court, #112 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year! Months Days Hours DEM 2 □ F 20, 1927 GA 82 Director 258-34-2493 Mav Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The state of the than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, Ire Regical Eventing must be rediffied at my or other traumatic event, Ire Regical Eventing must be rediffed at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 No Funeral Director Bowie MD Prince George 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20716 USA 3800 Enfield Chase Court, #112 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☑Yes 2 ☐
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☑ No Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chief Building Engineer HVAC 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertie Shipes William Ford ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7653 Clark Road, Hanover, MD 21076 permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once. Charles H. Ford/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Sept. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Springfield Cem.Annex Springfield, GA 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. J. Ken Skils M01053 313 Talbott Ave., Laurel, MD 20707 23a. P rrf1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 Z No 1 ☐ Yes 25. Was case referred to ____ cal examiner? Be 26. Place of Death (Check only Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Registrar DHMH 17 Rev 1/2001

Box 68760.

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

31. Date filed (Month, Day, Year,

Year)

Lynanne Farson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

09-06855 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0714 hrs September 2, 2009 Κ. **Medical Examiner** Farson Lynanne c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Carroll Westminster Carroll Hospital Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. Aug 31, 1956 Country) IA Director 53 480-78-4556 2 X F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 V No s 23a or 28a-f show a notified at once. Eldersburg Carroll MD oernit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shi Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 1303 Placid Drive 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married Yes Specify: White Yes 2 X No specify: If Yes. Give Year 4 X Divorced 3 Widowed other than "natural", the Medical Examiner ş 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 Health Care Director of Admissions 4 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucille Blackwell Frank H. Kerr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 107 Deimling Road Pittsburgh, PA 15229 Mrs. Tracey Kerr Zewe (Sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Sykesville, MD 9/6/2009 All County Cremation Donation 5 Other Specify 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, P.A.
PO Box 195 Sykesville, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and **Physician** failure. List only one cause on each Death /Medical Hypertensive cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical 23a,27,permE, g896 10/5/09 TT X UNPENDED AMENDED Box 68760, 23d. Date of delivery tending physi use as the bu 23c. If yes, outcome of pregnancy IF FEMALE: 3 Ectopic pregnancy Day Year Month 23b. Was decedent pregnant in the Fetal death Live birth Pregnant at time of death 5 Other (Specify) n signed by the atte 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 ✔ Unknown Þ Completed 24b. Were autopsy findings available 24a. Was an has been s 2 should prior to completion of cause of autopsy death? performed? 2 No 1 🗸 Yes ✓ Yes 2 No certificate h 26. Place of Death (Check only one) this certifi 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: 1 Inpatient Nursing Home 5 Residence 6 Others DOA 2 V ER/Outpatient 3 1 🗸 Yes No 28a, Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No Pending Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 or Town, State) Suicide determined (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 2, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 31. Date filed (Month, Day Year 32 Registrar's Signatur

DHMH 17 Rev 1/2001 **OCME 2006**

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ye ar Month 310PM **Physician** 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Baltimore 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Under 1 Year | If Under 24 Hrs. Security Number **Funeral** Months Days 6622 Yrs Director Usual Residence of Decedent 10d. Inside City Limits City, Town or Location 10a. State 10h. County 28a-f show ed other than "natural", or items 23a or 28a-f showevent, the Wedleal Evanther nust be nothing at 1XYes 2□No + More Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Race - American Indian, 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2X No Baltimore, Maryland 21215-0036 ρ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any Injury or other traumatic event, the Navidouse. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Koerner 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 108/2009 MOHIMORE 5 ☐ Other (Specify) ce U ensee 22. Name and Address of Facility 21. Signature Funeral S 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Myocardia /Medical Due to r as a consequence of): Examiner Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) I∐Yes 2 ☐No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 2 **N**O 1 ☐ Yes 1 Inpatient Certification: To 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in any arisk and are all are all and are all are all and are all and are all are all are all and are all are all and are all are al 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and

State Registrar

te 31. Date filed (Month, Day, Year) SEP 0 9 20

and address of person who

ersitu 32. Pegistrar's Signatur

mpleted cause of death (Item 23a) (Type

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year A M **Physician** 450 02 2009 September Jaule /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country)
 NTV If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Age (In yrs. last birthday) Min **Funeral** NY 1 □ M 2 X F 63 133-36-7760 **Director** Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.

nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10h. County or 28a-f show notified at 10a State Baltimore 1X Yes 2 □ No MD Director 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ral", or items 23a or Examiner must be 21224 USA 159 N. Streeper Street Funeral Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Black Specify Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Medical Elementary/Secondary (0-12) 12 College (1-4 or 5+) Education Teacher the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gloria H. Taylor Unknown ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 159 N. Streeper St., Baltimore, MD 21224 Phyllis Savoy / Daughter permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other trai 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition W. Arundel Crematory 9/5/2009 1 Burial 2 Cremation 3 Removal from State Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rendon-Bailey Funeral Home, PA 21. Signature of Funeral Service Licenses let 3 2818 E. Baltimore St., Baltimore, MD 21224 Mi1452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiac **Physician** Dirre disease or condition resulting in death) Due to (or as a consequence of): /Medical coronary artery disease **Examiner** Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner death certificate be executed burial-transit that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown P.0. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed' 2 110 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 ☑ Yes 2 ☐ No Hospital: 1
Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir မ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Medical Certification: Injury 1 Natural 5 Pending investigation 1 Yes 2 No M 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

*S*tate

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

/ear) 32. Hagustran's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

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600 North Wolfe St, Baltimore, MD, 21287

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		Northwest Hospital Co	enter			Randallstown	If Under 24H	rs 8 Date of Bit	HD/MM/DD/XXXXV 9	Birthplace (State or
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Ce m Se ell	의	19a. Informant's Name/Relation Tammy Cleav	ship (Type, Print)		19b. Mailin	g Address (Stree	t and Number	or Rural Route No	umber, City or Town,	State, Zip Code) MD 21117
MD nd 2 sho aith and m 27 is aumati			er / Mo	ther		o Oakme sition (Name of cer		Date	20c. Location - C	MD 21117
s l an of Heal		20a. Method of Disposition 1XXBurial 2 Cremati	on 3 Removal	from State	crematory of o	ther place)		. /1 1 /00	Clange	ville, MD
Page ment of tant:		4 Donation Other	Specify:	Me	moria	1 Dark	s of Facility E	rkhardt	Funeral	Chapel P.A.
Baltimore, permit. Pages 1 a Department of He Important: If ite		21. Signatur of Juneral Service	e License	-	111	605 Rei	sters	town Rd	. Owings	Mills, MD2111
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	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or a	s a consequence	of):					
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Division of Vital Records, P.O. Box 68760, rat or Attending Physician: The law requires that the death certificate be tras fler edath. "In Director: After this certificate has been signed by the attending physicilled in by the funeral director, page 2 should be detached for use as the built.		Part II. Dther significant con	ditions contributing	ng to death but not	resulting in the	e underlying cause	given in Part I			Probably 4 Unknown
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Vital Records, ysician: The law requir this certificate has been s director, page 2 should	ple							pe	erformed? d	rior to completion of cause of eath? Yes 2 No
Rec The I	Con					26 Pla	ce of Death (Cl		es 2 No 1	163
on of Vital Rectending Physician: The Besth. The Part or: After this certificate the funeral director, page	Be	25. Was case referred to med examiner?		✓ Inpatient 2	ER/Outpatie		Io.	lursing Home 5	Residence 6	Other:
1 of V ling Phys After thi funeral di	-	1 Yes 2 No 27. Manner of Death	28a. D	Date of Injury Month, Day, Year)	28b. Time o	, ,	jury at Work?		ibe how injury occurre	ed
on c ending ath. or: Af	tion		Pending Fd	9/3/09	Fd 8:	3 / DIII	Yes 2X N	1		D i N arbar City
ivision or Attend after death. Director:	Certification:	3 Suicide 6 X (28e.	Place of Injury - Al			e building, etc.	28f. Location or Tov	on (Street and Number vn., State) 120 0	er or Rural Route Number, City akmere Rd
Div pital o	Sert	4 Homicide		ecify) found					ngs Mills	
Division Division To the Hospital or Attend within 24 hours after death within Funeral Director: completely filled in by the	cal	(Oriobit orii)	g Physician: To the	e best of my knowl asis of examination	edge, death oc n and/or investi	curred at the time, gation, in my opini	date and place ion, death occu	e, and due to the rred at the time, o	cause(s) and manner date and place, and d	ue to the cause(s)
To the within complete	Medical	one) 2 Medical 29b. Signature and title of ce	and manr	ner stated.			ense number			ed (Month, Day, Year)
	2	Zab. Signature and title of de		Λ		0.0	C.M.E.		September	8, 2009
		30. Name and address of pe	_		tem 23a)					
Ø V		Donna M. Vincenti		ınt Medical Ex	aminer 1	11 Penn Stre	et, Baltimoi	e, MD 21201		
S	tate	31. Date filed (Month, Day, Y	0	2 Registrar's Sign	nature A	arked				

09-06	955	
7aire	Stanual	Gross

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			r State		Certifica	ate of	Death				g. No.	4		
Physici edical Exami			ecedent's Name (First, Middle	e,Last) Stan	ua l		Gros	s	2. D M S	Date of Deat Month eptembe	Day r 5, 200	Year	23	ne of Death 328 hrs
edicai Exami	nei		acility Name (if not institution	_		41	b. City, Town, or Lo				4c. C	County of D		
			Prince George's Hospi				Cheverly			. Date of Bir	1	ince Geo	_	o (State or
Funeral		5. S	ocial Security Number	6. Sex 7. Ag	e (In yrs. last birl	thday)	If Under 1 Year Months Days	If Under 2	Min.			F	oreign Country)	
Director		5	78-15-7181	1 XM 2 F	21	Yrs.	World Suy]	<u> 11 1</u>	9	87	Country)	DC
,			al Residence of Decedent State 10b. County		10c. City, Town	or Locatio	on						10d.	Inside City Limits
w any		10a				olum							1 [Yes 2 X No
yland 1-f sho	횭	100	MD Ho	oward		OTUII	10f. Zip Code			1	09. Citize	en of What	Country?	
t t e Mar or 28:	Director		5526 Vantang	e Point R	oad		21	.044				U.S	. A .	
vith the s 23a e noti	ᆵ		Marital Status	12. Was Decedent	t Ever in U.S.	13. Was	s Decedent of Hisp	anic Origin	n? (Specif	fy Yes or No)- 1	14. Race - A		ndian, Black,
leath v r item	Funeral	1 [. Marital Status X Never Married 12. Was Decedent Ever in U.S. X Never Married 2 Married 12. Was Decedent Ever in U.S. X Never Married 2 Married 12. Was Decedent Ever in U.S. X Never Married 2 Married 12. Was Decedent Ever in U.S. Yes 2X No Specify: X No Specify: Specify: X No Spe								Bla	ck		
after (Ş ₽			orced If Yes, Give Year or Dates:	1-1-4) 40-	_	Yes 2X No		ind of work	k done		ind of Busir	_	
1215-0036 de filed within 72 hours after death with the Maryland fental Frygeier. revent, the Medical Extension or items 33a or 28a-f show event, the Medical Extension or 18a-f show event, the Medical Extension or 18a-f show	Completed by	15	5. Decedent's Education (Spe Elementary/Secondary (0-12)			during m	ost of working life.	DO NOT u	se retired))				
36 iin 72 ii. ihan "dieal"	l be	١,	2th grade	na		Sa	lesman						Sho	e Store
d with	5	17.	Father's Name (First, Middle	, Last)			1	8.Mother's	Name (Fi	irst, Middle,	Maiden \$	Surname)		
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than se event, the Media	Be	K	Kenneth S. 1	Burrill			g Address (Street	Darr	nav	Gross	mber Cit	ty or Town	State, Zin	Code)
21 hould nd Me is ma			a. Informant's Name/Relations		2.0									21044
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Tiem 27 is marked other than "naturaly", or items 23a or 28a-f sho r tranner ovent, the Medical Ex miner minist be notified at once.		20:	Darnay Gross	s Simms-Mo	20b. Place	e or Dispus	SILION (Nathe of con	netery,	201n	C ROE	20c. L	_ocation - 0	City or Tow	m, State
nore, ages 1 and of the fitter of the other to			X Burial 2 Crematio	n 3 Removal from S			herplace) norial E	o a rk	9/1	2/09	[M	oodl	awn.	МД
를 들 을 <mark>크</mark> .	٠.	4-	Donation 5 Other S Signature of Funeral Service	pecify:	KING		Name and Address			2/05		0041	<u>,</u>	
Balti permit. Departi Importi			XYON ALA U	Sharan		143	300 Waba	ash A	Ave.	Balt	imo	re,		21215
Physician	Н	23	Part I. Enter the disease, of failure. List only one cause	r complications that cause	ed the death. Do	not enter t	the mode of dying,	such as ca	ardiac or re	espiratory a	rrest, sho	ock, or hea	rt A	pproximate Interval Between Onset and Death
Medica camine			mediate Cause (Final diseas	e a <u>Asthma</u>							_			
		or	condition resulting in death)	Due to (or as a con	nsequence of):									
	ğ	5 if :	equentially list conditions, any, leading to immediate	Due to (or as a cor	nsequence of):								1	
	Evaming	Ca (L)	iuse. Enter Underlying Cause Disease or injury that initiated	Due to for as a sor	nsequence of):	_								
uted Id	i i		vents resulting in death) Last				005.0	120 10	O mm		_			
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760, cate be			FEMALE: b. Was decedent pregnant in		come of pregnan	су	etal death 3	Ectopia	c pregnan	ICV	23	d. Date of Month	delivery Day	Year
Box 687 death certific	Sc as	Puysician 1	past 12 months?		t at time of death	-	other (Specify)							
30X death	TOI D	1		Inknown g Unknown						00 - Di			buto to the	e cause of death?
that the death certificated by the attending			art II. Other significant cond	litions contributing to de	eath but not resul	lting in the	underlying cause	given in Pa	art I.					bly 4 Unknown
s, P.O iires that i		g Dá								24a. W		24b. V	Nere autor	osy findings availabl
ords, P w requires t as been sign	shour	blet								au pe	topsy rform <u>ed</u> ?	, r	orior to con death?	npletion of cause of
Reco	page 7	Completed							(5)		s 2	No 1	✓ Yes	2 No
tal Rection: The		99 2	5. Was case referred to medi examiner?					Other		g Home 5	Resid	dence 6	Other:	
Physic rthis	E G	ے ۲	1 Yes 2 No 7, Manner of Death	28a. Date of	atient 2 F	8b, Time o		ury at Wor		28d. Descri			red	
Civision of Vital Records, as or A tending Physician: The law requires after ceath.	funer	ë É	4 [X] Manager	(Month, Da				Yes 2	No					
SiO Arten r ceath	by the	g	2 Accident In	vestigation 28e Place of	of Injury - At home	e, farm, st	reet, factory, office	building, e	etc.	28f. Locatio	n (Street	and Numb	er or Rura	Route Number, Cit
F. J. O. T. S. P. S. P. S. P.	u p		3 Suicide 6 Co	ould not be etermined (Specify)						or low	n, State)			
Livision of Vital Records, P.O. Box 68760, To the Hospital or Atending Physician: The law requires that the death certificate be executed within 24 hours after ceath. To the Funeral Director: After this certificate has been signed by the attending physician and	completely fill d in by the funeral	<u>0</u> 2	0.0-45	Physician: To the best of	of my knowledge,	, death occ	curred at the time,	date and p	olace, and	due to the d	ause(s) a	and manne	er as stated	l. cause(s)
o the	omple	g		Physician: To the best of examiner:On the basis of and manner stat	examination and ted.	or investig				it the time, o	290	Date sign	ned (Mont	h, Day,Year)
H 3 F	ō	ž 2	9b. Signature and title of cer	üfier			i	nse numbe C.M.E.	21			eptembe		
			Moupout	mel Knill				√.1¥I.∟.						
	1	3	30. Name and a dress of person Margarita Korell MD		of death (Item 2)	за) r 111	Penn Street,	Baltimo	re, MD :	21201				
	Q4-	ato 3	Margarita Koreli ML 31. Date filed (Month, Day, Ye											
Reg			CED 0 9	2009 Sense		par	Ker .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TEM#5, 10d, perFH, G895, 9/16/09, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month GEDRGE SEPTEMBER **Physician** 7.31 AM DOROTHY JEAN 2009 02 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 F June 5, 598 94-1380 Michigan Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Exarcinar must be notified at 1 XYes 2 No Director Texas Tarrant Benbrook 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10125 Orlando Drive 76126 U.S.A. Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1
Yes 2
No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the "action once. Elementary/Secondary (0-12) College (1-4or 5+) Accounting Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Constance Woods James Latta. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, informant's Name/Relationship (Type, Print) 10125 Orlando Drive Benbrook, Texas 76126 (Husband) John George 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ROSE HILLS MEM. PARK 9/8/09 WHITTIER, CA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles S. Zeiler and Son, Funeral Home 6224 Fastern Avenue Baltimore, Maryland 21224 pace Soil Della 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA DAYS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23d. Date of delivery ves, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗌 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ STENOSIS AORTIC 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown certificate has been sirector, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No OF TRANSPLANTED 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 ☑ Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ptember 02, 2009 00065097 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JANAKI DEEPAK

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Census

22 SGREENEST, BALTIMORE, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. smend #State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Certificate of	Death	Reg. N	lo.	20010
		u	Decedent's Name (First, Middle, Last)	Capia		Date of Death MonthD	ay Year	3. Time of Death
	Physicia /Medic		Ram Saran Gupta	CUPTA		PHEMDER		12:36fM
	Examin	er	4a. Facility Name (If not institution, give street and number)	Baltimore	or Location of Death	4	c. County of Death	
			The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday) If Under 1 Year	If Under 24 Hrs. 8.	Date of Birth	n/a 9. Birthp	lace (State or Foreign
45 -	Funeral Director		213-08-9860 ^{1 XM 2 □ F} 83	Yrs. Months Days		(Month, Day, Year, 11 , 1	. 1	India
	and		Usual Residence of Decedent 10a. State 10b. County 10c. County	City, Town or Location			1	0d. Inside City Limits
	Maryl	ţo	Maryland Prince George's	Laure1				1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number	10f. Zip-Code		10g. C	Citizen of What Count	try?
	th with		13815 Shannon Avenue		0707		United St	ates
	r dea tems er mu	Funeral	11. Marital Status 12. Was Decedent Ever in the Armed Forces?	J.S. 13. Was Decedent of If Yes, specify Cuk	Hispanic Origin? (Specify ban, Mexican, Puerto Rica	Yes or No- an, etc.)	14. Race - America Black, White, e	
036	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show wit, the Medical Examiner must be notifiled at	by	1 ☐ Never Married 2 😿 Married 3 ☐ Wes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No	Specify:		Specify: Asia	an-Indian
21215-0036	"natura dical E	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	e during most of working	16b.	Kind of Business/Inc	dustry
12	withir ene. than	dmc	Elementary/Secondary (0-12) College (1-4 or 5+)	Diplomat	,	Go	overnment	of India
р 2	filed Hygir other ent, th	Be C	17. Father's Name (First, Middle, Last)	DIPIOMAC	18. Mother's Name (Fi			
lan	should be fand Mental Hamarked of	To B	Lachiran Gupta		Ramrati	L Guj	ota	
Maryland	2 shou and N is mai		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Stree	at and Number or Rural R	oute Number, City	or Town, State, Zip	Code)
	1 and 2 Health a tem 27 i		Adarsh Kumar/son	13815 Shannor			aryland 20	
altimore,	8 4 = 0		1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State	Place of Disposition (Name of cemetery, crematory or other place arounded Crematory or other place).	1		Location - City or To	
altir	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	22. Name and Addr Donaldson				
<u> </u>	Q 2 2 2		Juante & Homes M0095	7 1411 Annay	polis Road C	denton,	Maryland	21113 Approximate
			23a. Part 1 Enter the disease, or complications that caused the decision, or heart failure. List only one cause on each line.		ning, such as cardiac of re	- CE		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conse	KY MKTE	RY DISE	ase		
1	Examiner		Due to (or as a conse	equence ory.				
	# -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	equence ut):				
	uted 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
Ć,	ificate be executed g physician and as the burial-transit		resulting in death) Last Due to (or as a conse	equence of):				
68760,	ate be hysicii the bu	Medical	d					
	entifica ing pl	~	IF FEMALE: 23c. If yes, outcome of preg	nancy			23d. Date of delive	one
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and arid director, page 2 should be detached for use as the burial-transit	Physician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	etal death 3 Ectopic pregnar	icy		Month	Day Year
, P.O.	that the ed by detac	by Pr	Part II. Other significant conditions contributing to death but not r	esulting in the underlying cause	given in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?
rds	quires n sign uld be	ed k				1 🗌 Yes	2 No 3 Prob	pably 4 Unknown
Seco	ne law red has beer ge 2 sho	Completed		-		24a. Was an autopsy performed?	prior to co	ppsy findings available empletion of cause of
a E	: The cate h r, pag		OF Mean and of such a such as a such		00 Fire of Booth (0	1 □ Yes 2		2 No
Ę	sician: Th certificate lirector, pa	Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐ DOA Or	26. Place of Death (Cather:		6 ☐ Other (Specif	iv)
ō	Physeral deral d	일 ::	27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Inju	ury at 28d	d. Describe how in		,
<u>0</u>	ath. :: After ie fune	atio	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation		ork? □ Yes 2 □ No			
Division of Vital Records,	I or Attending after death. Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At building, etc. (Spec	home, farm, street, factory, office cify)	28f.	Location (Street City or Town, Sta	and Number or Run ate)	al Route Number,
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page		29a. Certifier (check only 2 Medical Examiner: On the best of my king the best of my					
	the Ithin 2, the E	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. Licer	nse number	29d. [Date signed (Month,	Day, Year)
	७ № 0	-	DERITO, VIAD	DE	-S-000	921	Hemler	4. 2009
	6.1		30. Name and address of person who completed cause of death (I	tem 23a) (Type Print)		100	10. 60%	-)
	ソ٧		Barbara C. Heil M.	1D	600 No	orth Wolfe	St, Baltimo	re, MD, 21287
	Sta Regist		31. Date filed (Month, Day, Year) SEP 0 9 2009 Service 32. Registrar's fig.	natura				

		-	State of Maryland / State of Maryland / Registrar	•	t of Health and e of Death	Mental Hygie Reg.	ب ادا با با	28611
П	Physicia		1. Decedent's Name (First, Middle, Last) ARBETT	A G	UY	2. Date of Death Septembe	Day 3, 2009	3. Time of Death 2:00pm M
4	/Medic Examin		4a. Facility Name (If not institution, give street and number) 5 Westgate Court	4b. City,	Town, or Location of Deat	h	4c. County of Dear	
	Funeral Director		5. Social Security Number 5.38-26-0201 6. Sex 1 M 2 L 7. Age (In yrs. last b)	yrs. If Under Months		8. Date of Birth	9. Bir	thplace (State or Foreign buntry)
C1212 DI	permit, ragges 1 and 2 should be fined within 72 hours after beath with the waryand Department of Health and Mental Hygiene. Important: If them 21s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Modical Extraction into the multiple of a once.	To Be Completed by Funeral Director	MD Baltimore 10e. Street and Number 5 Westgate Court 11. Marital Status 1 Never Married 2 Married 11 Never Married 2 Married 12 Was Decedent Ever in U.S. Armed Forces? 1 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4or 5+) Wylie Clarence Knipp 19a. Informant's Name/Relationship (Type. Print) Mr. James Guy (Son) 20b. Place ceme 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	a. Decedent's Usu (Give kind of wo life. DO NOT u Home! 9b. Mailing Address 20 South of Disposition (Natery, crematory or c View Mem	dent of Hispanic Origin? (and the property of	Specify Yes or Note Rican, etc.) orking me (First, Middle, Mail Mauck Aural Route Number, Conterstown, Date 200 S	City or Town, State, MD 21136 c. Location - City or Sykesville	A erican Indian, e, etc. nite //Industry Zip Code) Town, State
F	Thysician parameter with the price of the pr	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Description of the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the conditions) or the conditions of the	to not enter the modern to not enter the enter the modern to not enter the enter the modern to not ent	TAGUSERALITY HOX 195 Sykesv	ac or respiratory arrest		Approximate Interval Between Onset and Death
Box 6	death certi e attending id for use a	Physician/Medical	d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of death 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting	ath 3 ☐ Ectopic h 5 ☐ Other (s	pecify)	23e Did toha	23d. Date of do	elivery Day Year to the cause of death?
Records,	I he law requires that the drate has been signed by the bage 2 should be detached	Completed by	Part II. Other significant continions continuing to dearn out not resulting	g iii iiio dildonyiiig	and grown are a	1 Des 24a. Was an autopsy performe	2 No 3 F	Probably 4 Unknown autopsy findings available ocmpletion of cause of
Vita	ician: certifica ector, p	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	/Outpatient 3 🗆 D	Othor:	1 □ Yes 2 □ eath (Check only one) Home 5 □ Residence	ZNo 1 □Ye	s 2 □No
	ending Phy sath. or: After this he funeral d	Certification: To		b. Time of Injury M	28c. Injury at Work? 1 □Yes 2 □ No	28d. Describe how	injury occurred	Rural Route Number,
	e Hospital or Att 124 hours after de e Funeral Directo letely filled in by t	Medical Ce	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occurre a and/or investigation	d at the time, date and pla n, in my opinion, death oc	ace, and due to the cau	use(s) and manner te and place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and tipe of certifier		c. License number	54 5	d. Date signed (Mod	,2009.
			30. Name and address of person who combleted cause of death (Item 23 CRISTINA TWICH LYO	(Type, Print)	LVEDERE	NE,BI	92-TIMOM	ZE,MDZIZIS

State Registrar

CRISTINA TOU 31. Date filed (Month, Day, Year) SEP 0 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Jaime Manuel Garcia 11:40 P.M September 2009 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Baltimore Towson If Under 1 Year If Under 24 Hrs.

Manthe Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** ÐXXM 2 □ F 62 Director 216-62-2459 Yrs 6/14/1947 Mexico Usual Residence of Decedent shov 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director Baltimore City Maryland N/A 28a-f 1 A Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23a or Funeral 21218 618 Venable Avenue Mexico items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married ō Completed by 1 ☐ Yes If Yes, Give 2 No Maryland 21215-0036 Specify: Mexican Mexican Yes 2 No Specify: d Mental Hygiene. marked other than "natural", 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Improvement Home Improvement Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alfredo Garcia Emilia Simon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Mrs. Whitney E. Garcia/ wife 618 Venable Avenue Baltimore, Maryland 21218 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H cemetery, crematory or other place) Evans Funeral Chapel 1 Burial 2 Cremation 3 Removal from State September Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2009 6, 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 21. Signature of Fundral Service Licensee 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician woendocure umans disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Pregnant at time of death the 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed page 2 should neec 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Physician: The 2 No 1 Yes 25. Was case referred to medical examiner? Division of Vital funeral director. 26. Place of Death (Check only one) Be 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) WOSPICE 4 Nursing Home 5 Residence after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending injury work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 [29d. Date signed (Month, Day, Year) 29b. Signatur d title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rarus ST HARVES

DHMH 17 Rev 7/2009

State Registrar Day,

32. Registrar's Signature

		-	For State Registrar	aryianu / Depa <i>Cer</i>	rtificate of L			g. No.	28613
	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
*	/Medic	al .	DOROTHY L. GORSUCH 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	Septemb	er 8, 2009	
-	Examin	er	Presbyterian Home of Maryl		Towson			Baltimo	
	Funeral		5. Social Security Number 6. Sex 7. Ag	je (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 13,	Year) 9. Birt Co 1015 Man	hplace (State or Foreign untry) yland
	Director		Usual Residence of Decedent				July 10,	1515 [1101]	10d. Inside City Limits
	farylar f show	ō	10a. State 10b. County	10c. City, Town or Lo	cation				1 □Yes 2 □No
	r 28a-i	Director	Maryland Baltimore 10e. Street and Number	Towson	10f. Zip Code		10	ng. Citizen of What Co	
	23a o	ral D	400 Georgia Court		21204			USA	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Eventher must be notified at other traumatic event, the Madical Eventher must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Year or Dates:	No	Was Decedent of Hi If Yes, specify Cuba 1 □Yes XX No	Specify:		<i>Specity.</i>	hite
15-0	n 72 ho	Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usuat Occupa kind of work done of DO NOT use retired	ation luring most of worki)	ng 1	16b. Kind of Business/	ndustry
212	d withingiene.	Som	Elementary/Secondary (0-12) College (1-4or:	5+1	emaker			Own Hom	e
Maryland	ild be file fental Hy rked othe tic event,	To Be (17. Father's Name (First, Middle, Last) Clarence Creston Cathcart			18. Mother's Name	Edna Br		
Mary	1 and 2 should be filed v Health and Mental Hygi em 27 is marked other ether traumatic event, ti		19a. Informant's Name/Relationship (Type. Print) Barbara G Reisinger	Dtr 24560	ng Address (Street a	and Number or Rura Cer Point	Drive S	City or Town, State, 2 t Michaels	MD 21663
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once.		20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	putarey vari	ley Mausole.	m Sept	12,2009	Timonium	Maryland
Balt	permit. Departi Importa any Inj		21. Annature of Funer I Syrvice Licensee Amus Sylvan Actual Manual Company Manual Company	IRIS	6500 \	York Road	Baltimo	re, Maryla	The second second
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each 1	d the death. Do not entine.	ter the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
and the same	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a consequence of):	~ T				5 days
	Examiner			, a 551155 que to 51/1					
. V	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lose, Unsease or injury	s a consequence of):					
60,7	tificate be executed ig physician and as the burial-transit	al Exar	that initiated events c	s a consequence of):					
68760,	ificate g physi as the t	edical	d						
O. Box	ath cer attendir or use	Physician/M		2 Fetal death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	у		23d. Date of de Month	livery Day Year
Δ.	quires that the de n signed by the a lid be detached f	by	Part II. Other significant conditions contributing to death MG 1 1 - M 1 - L	but not resulting in the u	underlying cause giv	en in Part I.		bacco use contribute to es 2 ∑ No 3 □ P	o the cause of death? robably 4 Unknown
Division of Vital Records,	To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Completed					24a. Was a autops perform	ned? prior to death?	utopsy findings available completion of cause of s 2 \(\bigve{N} \) No
Vita	certific rector,	æ	25. Was case referred to medical examiner? Hospital:		ont 3 🗆 DOA Oth	26. Place of Deat			
of	g Physer this eral di	n: To	27. Manner of Death 28a. Date of In	ient 2 ER/Outpatie jury 28b. Time o lnjury	SIL SU DOA	y at		ence 6 Other (Special Other (Special Other)	эсігу)
sion	Attending r death. sctor; After by the funer	catlo	2 Accident investigation		M 1 □	Yes 2 □ No			Les I Florido Mumbros
Divi	l or Att after d Direct d in by	Certification: To		njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office		City or Town	treet and Number or R n, State)	urai Houle Number,
[e Hospita 24 hours Funeral etely filled	Medical C	29a. Certifier (Check only one) (Check only one) (Check only one)	of examination and/or it	th occurred at the ti nvestigation, in my o	me, date and place opinion, death occur	, and due to the or rred at the time, d	cause(s) and manner a late and place, and du	is stated. e to the cause(s)
N -	To the within To the compl	Me	29b. Signature and title of certifier	mo	29c. Licens	e number) 3 7 0 ((Se pte ~ Se	th, Day, Year) - 8,2007
			30. Name and address of person who completed cause of KENNETH GREENE, M.D. 670	death (Item 23a) (Type,	, Print) arles Str	eet, Taws			
	Sta Regist			trar's Signature					

09-06933

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mar	garet Lynn G		ion I- For State	Stat	e of Marylan		ent of Hea ate of Dea	alth and Mental H ath		No. 20	09 2861
	Physicia	ليسا	Registrar 1. Decedent's Name	e (First, Middle,L	ast)				2. Date of Death	. No Day Year	3. Time of Death
Me	dical Exami	ner			nn Glenno				September	5, 2009	0814 hrs
1	>		•	if not institution, uare Hospita	give street and numb	oer)	1	r, Town, or Location of Deat Sedale	n	4c. County of Dea Baltimore Co	
	Funeral		5. Social Security N			Age (In yrs. last birt	hday) If Ur	nder 1 Year If Under 24Hr	s. 8. Date of Birth	(MM/DD/YYYY) 9. E	
	Director		217-82-0		м 2Х г	46		nths Days Hours Mil	Septemb		eign ^{Opuntry)} Maryland
14866	w any	ŀ	10a. State	10b. County		10c. City, Town		Marak			10d. Inside City Limits 1 Yes 2 X No
7	ryland a-f she t once	į	Md .	Balt mber	.0.		White N	Zip Code	100	g. Citizen of What Co	ountry?
	the Ma sa or 28 stiffed a	Director		ffeld Av	renue			21162		USA	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Marri	ed 2 Mar	A man and E and	dent Ever in U.S. ces?		edent of Hispanic Origin? (Secify Cuban, Mexican, Puerl		14. Race - Am White, etc	
	after d	by F	3 Widowed	4 X Divor	ced If Yes, Give Year or Dates:			2 X No specify:		Specify:	White
	hours natur Exam				y only highest grade College (1-4			ual Occupation (Give kind of working life, DO NOT use re		16b. Kind of Busines	ss/Industry
	36 thin 72 te. than '	Completed	Elementary/Sec 12	oridary (0-12)	College (1-		tail Sto	ore Manager		Retail Fu	rniture
	5-0(led wi Hygier other		17. Father's Name	(First, Middle, L	ast)			18.Mother's Nan	ne (First, Middle, M	aiden Surname)	
	121 Id be fi dental narked event,	o Be	Charle		llier, Ji	ſ.	h Mailing Addre	Regina ess (Street and Number o	Friedell	ber. City or Town, St	rate, Zip Code)
	AD 2 2 shou n and N 27 is n matic	To			llier, Jr	- 77					is. Md. 21401
	re, Nand 1 and 1 Healt]		20a. Method of Dis	sposition	3 Removal from	20b. Place		Name of cemetery,	Date	20c. Location - City	or Town, State
	Pages rent of ant: I			Other Spe		Bayy		i i	-11-2009	Baltimore	City, Md.
	3alti ermit. Separtn mport		21. Signature of Fi	٨	()	6		and Address of Facility	Schimunek	FuneralH	lome
	Physician	_	23a, Part I, Enter t	disease, or c		used the death. Do n	ot enter the mod	5 Belair Rd. de of dying, such as cardiac	Notting or respiratory arre	ham, Md. st, shock, or heart	Approximate Interval
5.24	/Medical	1 5		nly one cause o	n each line.			cocaine int			Between Onset and Death
M	taminer		or condition result		Due to (or as a	consequence of):			0200020.		
		ē	Sequentially list co		Due to (or as a c	consequence of):					
	`	Examiner	cause. Enter Und (Disease or injury events resulting in	that initiated	c. Due to (or as a c	consequence of):	-				
	cecuted 1 and - transit		events resulting in	Last	d	7 07 00	<i>C</i>	E - 00F 0 /17	700 mm		
	ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed retor. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transi	Medical	X UNPENDE	<u> </u>				ı,E g895 9/16	/09 11 		
	6876 certificate nding phy se as the b		IF FEMALE: 23b. Was deceden		23c. If yes, o	utcome of pregnancy th	7 Fetal de	ath 3 Ectopic preg	nancy	23d. Date of deli Month	ivery Oay Year
	Box 6876 e death certificate the attending phy ed for use as the	sicia	past 12 month				5 Other (S	Specify)			
	D. Be t the de by the ached fi	Phy			9 Olikilos		ng in the underl	ying cause given in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
	ires that the signed by	d by							1 Yes	2 No 3	Probably 4 Unknown
	ords, w requires been sishould be	lete							24a. Was autop		re autopsy findings available to completion of cause of
	of Vital Records, g Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed							perfor	rmed? deat 2 No 1	th? Yes 2 No
	tal Rec cian: The certificate ector, page	Be C	25. Was case refe examiner?	erred to medical	Hospital:			26.Place of Death (Che			
	Physican this eral dir	2	1 ✓ Yes 27. Manner of Dea	2 No	28a, Date o	of Injury 28b	Outpatient 3 Time of Injury	DOA Ourel 4 Nur		Residence 6 0	Other:
	on of ending Pl ath or: After he funera	tion	1 Natural	5 Pendi	(Month,	Day,Year)	7:!6 a	1 Yes 2 X No	unk		
	Division tal or Attendir rs after death at Director: A led in by the fu	Certification	2 Accident 3 Suicide	6 X Could	not be 28e. Place	of Injury - At home.		tory, office building, etc.	28f. Location (S	Street and Number of	or Rural Route Number, City
8	hou hou		4 Homicide	deterr	(opcony)				White M	arsh, MD	
(To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only	Certifying Phy Medical Exam	ysician: To the best niner:On the basis o and manner st	f examination and/or	eath occurred a investigation, in	t the time, date and place, a n my opinion, death occurre	and due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
		βe	29b. Signature an	d title of certifier	and marrier st	atou.		29c. License number			(Month, Day, Year)
1			0-	-M				O.C.M.E.		September 6,	, 2009
	Ø V		Donna M.	Vincenti, MD		e of death (Item 23a) ledical Examine	,	nn Street, Baltimore,	MD 21201		
	S Regis	tate		SEP 0 0	2009 32. Re	strar's Signature	has	1.1			
C	OHMH 17 Rev 1/2			U D		OI	RIGINAL		<u> </u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #6 Per FH 6895 of Maryland Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 September /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner In. +302 licott Dad Birthplace (State or Foreign Country) If Under 1 Year Months Davs If Under 24 Hrs. 7. Age (In vrs. last birthday) Year) 1 □ M 3 F Days Hours Min. 88 Pennsylvania March 1,1921 138-16-1530 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 1 ☐Yes 2 🕅 No Directo Ellicott City Maryland | Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21043 USA 8720 Ridge Road Apt. 302 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify Specify: δ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner/ Operator Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ray Lewis Barney Levine ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4099 Choctaw Drive; Ellicott City, MD 21043 Maxine Salah Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Glen Burnie, Maryland 9-4-2009 Atlantic Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Sevice Liverse 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Qnset and Death** Immediate Cause (Final wans metastatio disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months Pregnant at time of death 5 ☐ Other (specify) □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 Deobably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner Leath 1 Letatural 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation. in my opinion, death occurred at the time, date and place, and due to the companion of the basis of examination and/or investigation. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

requires that the death certificate be executed P.0 Division of Vital Records, or Attending

Funeral

Director

should be filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be mulfilled at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, Ite Me

Physician

/Medical

Examiner

burial-tran

the attending pl

detached

been signed by should be detacl

page 2

After this certifile funeral director,

death.

within 24 hours after death

To the Funeral Director:
completely filled in by the

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

SEP 0 9 2009

29c. License number

29d. Date signed (Month, Day, Year)

monemo 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

aroleMil

09-06824 Deborah Gaster

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 28515

DOTAIT Gaster		For State	Certificate of	of Death			Reg. No		10	Time of Dooth
Physicia		edistrar Decedent's Name (First, Middle,Last)				2. Date of I	Day	Year		Time of Death 0915 hrs
edical Examin	er	Deborah Gaster		4b. City, Town, or	Location of	Septen		c. County o	f Death	
	4	a. Facility Name (if not institution, give street and number) 1702 Searles Road		Dundalk	Location	Journ 1		Baltimore		ty
E	E		In yrs. last birthday)	If Under 1 Yea		24Hrs. 8. Date o	f Birth (MI	M/DD/YYYY)	9. Birthr	lace (State or ennsy Ivania
Funeral Director		188-46-1190 1□m 2∏F		Months Day	s Hours	Min. Jan	23,	1956	Coun	try)
any		Jsual Residence of Decedent Oa. State 10b. County 10	Oc. City, Town or Loc	cation					1	Od. Inside City Limits
* .	_ P	enna Fayette	Uni	ontown						1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	01	10e. Street and Number		10f. Zip Code			10g. C	itizen of Wh		у?
the M a or 2	ä	473 Walnut Hill Road		154				USA		an Indian, Black,
ms 23	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	ispanic Origi an, M exican, I	n? (Specify Yes o Puerto Rican, etc.))		e, etc.	ari fridani, blass,
or ite	틢	1 Yes 2	No 1	Yes 2 X N	o specify:			Specify:	Whit	:e
s after	<u>a</u>	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade comp	leted) 16a Dece	dent's Usual Occup	ation (Give k	ind of work done	161	. Kind of Bu	usiness/In	dustry
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	during	g most of working lit	fe. DO NOT u	ise retired)		0	7.7	
36 thin 7, re. than	힐	12	Hon	nemaker_					Home	9
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	3	17. Father's Name (First, Middle, Last)				s Name (First, Mic			*1	
121 d be fi lental] arked	Be	William Gaster 19a. Informant's Name/Relationship (Type, Print)	19b. Ma	iling Address (Str	eet and Num	ISANNE Mo ber or Rural Rout	e Number	, City or Tov	wn, State,	Zip Code)
D 2 should and M 7 is m	٩	Belinda Gaster, Daughter		2 Searles			Mar	vland	2122	22
and 2 sho lealth and tem 27 is traumati	1	20a. Method of Disposition	20b. Place of Dis	sposition (Name of or other place)		Date	20	c. Location	- City or	Town, State
Ore ges 1 tt of H t: If i	ı	1 Burial 2 Cremation 3 Removal from State	M. 1 C.		Inc.	09/04/09		Balti	more	, Maryland
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati	ŀ	4 Donation 5 Other Specify: 21. Signature of Funeral Service Ligensee Thomas (regor (22. Name and Addre	ess of Facility	ty Of Ma	rvla	nd. I	nc.	
Balti permit. Departm Imports injury o		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Thomas 23a. Part I. Enter the disease, or complications that caused to failure. List only one cause on each line.		299 Frede	rick F	Road Bali	imor	e, Ma	<u>ryl</u> ai	nd 21228 Approximate Interv
Physician		23a. Part I. Enter the disease, or compretations that caused failure. List only one cause on each line.	the death. Do not en	ter the mode of dyir	ng, such as c	ardiac or respirato	ory arrest,	SHOCK, OF TH	eart	Between Onset an
xaminer		Immediate Cause (Final disease a. Dilated c		athy						-
Adminici		or condition resulting in death) Due to (or as a conse	quence of):							
	La la	Sequentially list conditions, if any, leading to immediate Due to (or as a conse	quence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a conse	equence of):		_		_			
led nsit	Exa	events resulting in death) Last								
execul an and al - tra	ical	X UNPENDED AMENDED 23a	,2/,per M	E g896 10	0/5/09	TT				
760, cate be executed physician and he burial - transit	Medical	IF FEMALE: 23c. If yes, outcome	ne of pregnancy		- 🗆			23d. Date Month		y Day Ye ar
687 ertifica ding p e as th	sician/I	23b. Was decedent pregnant in the past 12 months?	time of death 5	Fetal death Other (Specify)	3 Ectopi	c pregnancy		Worter		ouy
5.0. Box 687 that the death certific ned by the attending p detached for use as the second control of the seco	sici	1 Yes 2 No 9 Unknown g Unknown	5	Other (Specify)						
O. B r the d by the ached	Phy	Part II. Other significant conditions contributing to deat	h but not resulting in	the underlying cau	se given in P	art I. 236				the cause of death?
Division of Vital Records, P.O tal or Attending Physician: The law requires that t is after death. The instance After this certificate has been signed by lied in by the funeral director, page 2 should be detax	<u>8</u>						200			utopsy findings availa
rds, requir been s	Completed	_					a. Was an	'	prior to death?	completion of cause
e law te has	Ę					1	perform Yes 2		1 Y	es 2 No
I Re II. The rtifical	ြင္မ	25. Was case referred to medical		26.P		(Check only one				
Vita ysicia ysicia direct	e Be	examiner? 1 V Yes 2 No Hospital: 1 Inpation		atient 3 DOA	Other ₄	Nursing Home		esidence 6		er: Scene
of of ng Ph	<u> </u>	27. Manner of Death 28a. Date of Inj (Month, Day,)		,	Injury at Wo Yes 2	l l	ascribe no	, w mjary ooc	201100	
ion ttendi Jeath.	l af	A Natural 5 Pending Accident Investigation	njury - At home, farm				cation (St	reet and Nu	mber or F	Rural Route Number,
ivis or Al after of Direct	Certification:	3 Suicide 6 Could not be determined (Specify)	njury - At nome, ram	i, street, factory, on	ice building,		Town, Sta			
Spital hours neral	S		ov knowledge death	occurred at the tim	ie, date and r	place, and due to	the cause	(s) and mar	nner as sta	ated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After direcenfricate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	ical	(Check culy one) Certifying Physician: To the best of the control one) Medical Examiner: On the basis of examiner:	amination and/or inv	estigation, in my op	inion, death	occurred at the tin	ne, date a	nd place, ar	nd due to	the cause(s)
To t with To t	Medical	29h Signature and title of certifier			cense numbe			29d. Date s	signed (N	fonth, Day, Year)
	=	V / Junturke 110		C	C.M.E.			Septem	ber 2, 2	2009
101 pord		30. Name and address of person who completed cause of	death (Item 23a)							
IOUNV		Laron Locke MD Assistant Medical E	caminer 111	Penn Street, B	altimore,	MD 21201				
	State	OF COULD COUR	ar's Signature	Jarle!						
Rani	etra		0	6						

OCME

State of Maryland / Department of Health and Mental Hygiene

			For State Of Mary 16	•	rtificate of L			g. No.	28617
	Physical		1. Decedent's Name (First, Middle, Last)				2. Date of Death Month		3. Time of Death
	Physicia /Medic		Dorothy Jolissaint Head				August	31, 2009	1:30 p M
	Examin	er	ka. Facility Name (If not institution, give street and number)		4b. City, Town, or Finks	Location of Death		4c. County of Deat	
	Funeral		2912 Constellation Way 5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year		B. Date of Birth	9. Birt	hplace (State or Foreign
	Director		264-18-2366 ^{1□M 2} X 95	Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, EP 25,	1913 Loui	untry) Siana
	rland ow		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	ocation				10d. Inside City Limits
	a-fsh	ctor	Maryland Carroll	F	inksburg				1 □Yes 2 ▼No
	or 28	Dire	0e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
	s 23a	eral	2912 Constellation Way	118 112	210		ify Vas or No-	USA 14. Race - Ame	rican Indian
(0	fter de ritem	Funeral Director	11. Marital Status 12. Was Decedent Ever in Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, GiveA			ispanic Origin? (Spec an, Mexican, Puerto R	ican, etc.)	Black, White	
036	ours a		3X Widowed 4 □ Divorced If Yes, GiveX Year or Dates:		1 □Yes 2 □No	Specify:		Specify: C1	reole
21215-0036	2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Modeal Eventhar mark be notified at	Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired	during most of working		6b. Kind of Business/	Industry
212	l withir giene. r than	omo	Elementary/Secondary (0-12) College (1-4or 5+)	Nurs		•/		Health	ncare
pu	al Hyg	Be C	17. Father's Name (First, Middle, Last)	·		18. Mother's Name			
ylai	ould by Ment arked arked	2	Alfred Jolissaint				ian Moll		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the "Modal Eventhar mast be notified at once.		19a. Informant's Name/Relationship (Type. Print) Selonie Head Cortada/daughter	19b. Maili 2912	ing Address (Street Constella	and Number or Rural ation Way l	_{Route Number,} Finksbur	City or Town, State, 2	Zip Code) 148
Baltimore,	es 1 a of Hea fitern or othe		20a. Method of Disposition 20l 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7	b. Place of Disponentery, cre	osition (Name of ematory or other place	ce) Da		0c. Location - City or	
Ë	t. Pag rtment rtant: I		4 Donation 5 Other (Specify)		Memorial Par	1	1	Sykesville	
Bal	permi Depar Impor any ir		21. Signatore of Funeral Service Licensee	F	laight Fur P.O. Box 1	neral Home 195 Sykesv:	& Chape ille, MI	1. P.A. (4)	10-795-1400)
			23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line.	eath. Do not er	nter the mode of dyir	ng, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	0000	len dry	cae			5 years
Ч	/Medical Examiner		Due to (or as a cons	sequence of):					
		Je.	Sequentially list conditions, b. Due to or as a cons	se wence of:					
W	ecuted ind transit	Examiner	Sequentially list conditions, if a b. Due to or as a constant cause. Enter Underlying Cause (Disease or injury that initiated events						
66. M	tificate be executed ig physician and as the burial-transit		resulting in death) Last Due to (or as a cons	sequence of):					
68760,	ficate g phys	ledical	d				100		
Вох	leath cert attending for use a		IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ F		☐ Ectopic pregnanc	·v		23d. Date of de	
P.O. B	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending the Funeral director, page 2 should be detached for use.	Physician/N	in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown 9 □ Unknown		Other (specify)			Month	Day Year
	w requires that the designed by the should be detached		Part II. Other significant conditions contributing to death but not	resulting in the	underlying cause giv	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
rds	en signuld be	ed by	PARUXY 8 med Ahual Pib	rellaha			1 ☐ Ye	s 2 <mark>∭uN</mark> o 3□P	robably 4 🗌 Unknown
Division of Vital Records,	law re nas be 2 shc	Completed					24a. Was ar autopsy	v prior to	utopsy findings available completion of cause of
a H	n; The icate { ; page						perform 1 □ Yes 2	1 ☐ Yes	2 □No
Zi.	siciar certif irector	Be C	25. Was case referred to medical examiner? 1 □ Yes 2 □ No Hospital: 1 □ Inpatient 2	□ EB/Outpatie	ont 3 🗆 DOA Oth	26. Place of Death	./	nce 6 ☐ Other (Spe	10164)
of	g Phy ter this teral d	n:Tc	27. Manne Death 28a. Date of Injury	28b. Time				w injury occurred	City)
ior	endin sath. or: Af he fur	atio	2 Accident investigation		M 1□	Yes 2 □No			
i Vi	or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp	t home, farm, si ec <i>ify)</i>	treet, factory, office	2	8f. Location (Sti City or Town	reet and Number or R , State)	ural Route Number,
	spital nours a neral I		29a. Certifier 1 Certifying Physician: To the best of my						
10	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one) 2 Medical Examiner: On the basis of examiner and manner stated.	nination and/or i					
_	vith To t	Σ	29b. Signature and title of certifier		29c. Licens	se number 31660		9d. Date signed (Mon	
			30. Name and address of person who completed cause of death ((Item 23a) /Time	Print)				
657			THOMAS V. CALLOW IT	MA	VOT2 176	er Author	cues	min ster	marielas
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 7 2009 32. Registrar's Si	ignature	aked				
	negisti	aı	SEL O SOUS CONTINUES	1. 1					

DHMH 17 Rev 1/2001

			State of Maryland / Dep 1 - State Registrar Ce	ertment of Fertificate of			enez 0 0	9 28613
r	N		Decedent's Name (First, Middle, Last)			2. Date of Death Month	n Day Yea	3. Time of Death
	Physicia /Medic		Otis Edwin Howard			Sept.	1, 2009	5:57pm ^M
74.	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, o		eath	4c. County of D	
*			Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday.)) If Under 1 Year	polis	rs. 8. Date of Birth	9.1	
	Funeral Director		401-20-6337 1X M 2 F 84 Yrs.	Months Days	Hours M	Nov 15,	1924	Birthplace (State or Foreign Country)
	PL ,		Usual Residence of Decedent					10d. Inside City Limits
	arylaı show	J.	10a. State 10b. County 10c. City, Town or L			1.4		1 □Yes 2 □XNo
	the M	Director	FL Marion	10f. Zip Code	mmerfie		g. Citizen of What	
	with with		10337 S.E. 178th Street		491			USA
	be filed within 72 hours after death with the Maryland tital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be rediffed at	Funeral		. Was Decedent of I	Hispanic Origin?	(Specify Yes or No- uerto Rican, etc.)	14. Race - A Black, W	merican Indian,
9	after or ite		1 Never Married 2 Married 1 Y Yes 2 No WWII	1 ☐ Yes 2 No		ierto Mcari, etc.)		White
	ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			10	16b. Kind of Busine	
5	n 72 l	olete	(Specify only highest grade completed) (Give	edent's Usual Occup re kind of work done DO NOT use retire	during most of i d)	working	TOD. KING OF BUSINE	ss/madsu y
212	l withi giene. r thar	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Quality	ality Con	trol		Automob	ile
Maryland 21215-0036	e filec al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last)		l	Name (First, Middle, M	·	
ylaı	should be filed and Mental Hygi s marked other umatic event, II	10	William Otis Howard		L	lorence Ro		
Jar	2 sho		, , ,			Rural Route Number, Summerfic	_	
	1 and Health em 27 ither ti						20c. Location - City	
no	Pages nent of int: If its iry or o		1∑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crestlawi	position (Name of ematory or other pla n_Mem. Ga	ce) ¦ rden's '		·	sville, MD
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Mente Important: If Item 27 is marked any Injury or other traumatic e-		- Domain (Pp-10)			ME & CHAPE		
ñ	Deg any		Brian L. Haist moorey P	0 Box 195	Sykesv	ille, MD 2	1784 · A ·	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dyi	ng, such as car	diac or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	TORY	1-A)	LURE		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	INICE	D	11-210	\	
	M2.701111101	P.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	ANCE		srage 1	V	1
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
o,	e exec an an rial-tra		resulting in death) Last Due to (or as a consequence of):					
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	d					
9	ertific ding p	Mec	IF FEMALE:					
Rox	eath certific attending p	ian/	In the past 12 months?	Ectopic pregnand	су		23d. Date of Month	delivery Day Year
Ö	uires that the de signed by the a d be detached fo	Physician/Me	1 Yes 2 No 9 Unknown					
", J.	s that ined b	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause gi	ven in Part I.	23e. Did tob	pacco use contribut	e to the cause of death?
Records,	w require been sig should b	ed b				1	s 2 □ No 3 □	Probably 4 Unknown
ပ္ပဲ	law re las be	Completed		•		24a. Was ar	y prior	e autopsy findings available to completion of cause of
		Con				perform 1 □ Yes 2	ned? deat	h? Yes 2□No
Vital	sician; The certificate rector, pag	Be	25. Was case referred to medical examiner?	_ Tot	hor:	Death (Check only one		
	Phys rr this eral dir	1: To	27. Manger of Death 28a. Date of Injury 28b. Time	of 28c. Inju	iry at	ng Home 5 ☐ Reside 28d. Describe ho	ence 6 Other (some of the control of	Specify)
on	nding P ith. :: Atter 1 e funera	atior	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation		rk?]Yes 2.⊟No			
Division of	il or Attendii after death. I Director: A d in by the fu	Certification: To	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined building, etc. (Specify)	treet, factory, office		28f. Location (St. City or Town	reet and Number o. n, State)	r Rural Route Number,
	pital or Attencours after deathers after deatheral Director: filled in by the					l.		
7	Hos Tun Tely	Medical	29a. Certifier 1 ☐ *Certifying Physician: To the best of my knowledge, dea (Check only one) 2 ☐ *Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the t investigation, in my	time, date and p opinion, death o	place, and due to the concourred at the time, do	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
V	To the Hos within 24 h To the Fun completely	Mec	29b. Signature and title of certifier	29c. Licen	se number	2	9d. Date signed (M	onth, Day, Year)
	C>F0		> Our Bhander, MD	. \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	668	318	09/01	09
	7		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)		Annaporis	. ^^-	211121
			Arun Bhandari, ND, 2001 Med	lical PK	wy x	mapers	1410	21401
	Sta Regista		31. Date filed (Month, Day, Year) \$2. Registrar's Signature	Mal				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend \$5at Ber Mary 6885/ Debay ment of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) : 43 PM CYNTHIA 29 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death RALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER N/A Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6115 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🗓 F MARYLAND 33 JUN 19 1976 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location MXYes 2 ☐ No BALTIMORE MARYLAND N/A 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 231 N CHESTER STREET U.S.A. 21231 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ∐Yes 2**X**Xlo If Yes, Give Year or Dates: 1 K Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2XXNo Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LAB TECH 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JEAN CHARLOTTE CRAWFORD JOSEPH HENRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2035 E. Orleans St., Baltimore, Maryland 21231 Jean Henry/Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify)
Signature 1 The Sery selection BALTIMORE, MARYLAND : 09-05-09 KING MEMORIAL PARK 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Epter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BACTEREMIA I WEEK SEPSIS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MORBID OBESITY 24b. Were autopsy findings available prior to completion of cause of death? ACUTE RENAL FAILURE 24a. Was an autopsy performed? 1 ✓ Yes 2 □ N 1 ☐ Yes 2 ☐ No 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

/Medical **Examiner** Hospital or Attending Physician: The law requires that the death certificate be executed aftending physician and for use as the burial-trar Box 68760, Division of Vital Records, P.O.

Examiner certificate has been signed by the rector, page 2 should be detached this certific al director, After 1

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be (

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Evantian matternation at

Maryland

the

death with

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Health a

Department of Health Important: If item 27 any injury or other treatment.

Physician

3altimore, Maryland 21215-0036

Physician/Medical Be Completed by

Medical

Certification: To

within 24 hours after death

To the Funeral Director;
completely filled in by the

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

29b. Signature and title of certifier

29c. License number 1386847903 AUG. 29,2009

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 S. GREENE STREET, BALTIMORE MO 21201 SMITH

31. Date filed (Month, Day, Year) State Registrar

CATHERINE

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 09:37" ack ancu 200 /Medical 4a. Facility Name (If not institution, give street and numbe City, Town, or Location of Death 4c. County of Death Examiner Lurversita altimore N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. Davs 1 → M 2 □ F Months Hours Director Apr 5, 1931 So. Carolina 216-28-4529 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be redified at once. 1 XYes 2 ☐ No Director Baltimore N/A Maryland 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21201 USA 833 West Pratt Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □Yes 2 □ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ Specify: Black 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **Baltimore City Schools Employee** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances Henry Frank Henry ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 833 West Pratt Street Baltimore, Maryland 21201 Anna Owens Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Qther (Specify) 09/10/09 Baltimore, Maryland Arbutus Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md. 11.9-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cluse (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner (esume Sequentially is the diffusion of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran be exec Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical law requires that the death certificate as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed death? certificate Division of Vital 2 No 2 🗆 No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☑ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident ould not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date stoned (Month, Day, Year) 30. Name and address of person who comp ted cause of death (Iten 23a) (Type, Print) South Greenest Yeatts Billimase Dale

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

SEP 09

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 852 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:10 P M September 3,2009 Theresa G. Hardisky 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Baltimore Oak Crest Village Parkville 8. Date of Birth 9. Birthplace (S (Month, Day, Year) 9. Missouri If Under 1 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number Months Days Hours Min 1 □ M 2 □ F Yrs. 218-12-3798 86 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location Parkville 1 ☐ Yes 2 🛣 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3520 Trevor Place 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes X□No Specify: white Specify: 3√ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Of Maryland Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Madeline Browns Horace Caraker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel J. Hardisky-son 2742 Superior Avenue-Baltimore, Maryland 21234 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Durial 2 ☐ Cremation 3 ☐ Removal from State ☐ Conation 5 ☐ Other (Specify) Parkwood Cemetery Sept.8,2009 Parkville, Maryland 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services 21. Signature of Funeral Service Licensee 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) schemic Due to (or as a consequence of): esthenia Cayer mally not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify)

Physician /Medical Examiner

Important; If it any Injury or o

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

ral", or items 23a or 28a-f shov

Baltimore, Maryland 21215-0036

Director

Completed by Funeral

Be

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Examine

Be Completed by Physician/Medical

Certification: To

Medical

29a. Certifier

jo

that the death certificate be

Hospital or Attending Physician:

Division of

Box

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sompletely filled in by the funeral director, within 24 hours after death

To the Funeral Director:

9 Unknown	9 ☐ Unknown	
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 2 160 3 ☐ Probably 4 ☐ Unknown
- 1		24a. Was an autopsy performed'? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Dea	th (Check only one)
examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing H	ome 5 Residence 6 Other (Specify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time of Injury at Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined		28f. Location (Street and Number or Rural Route Number,

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifler 2 CRNP

R043580

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TINE

Walther Blud. Batto. MD

State Registrar 31. Date filed (Month, Day, Year)

PRACTITIONER

David Hunt 09-06925

0-06925 NK UNK				: in Black In yland / Depa							gible.	0.0	0.000
	ل	I- For State Registrar 1. Decedent's Name (First, Middl			tificate o						eg, No.	201	3. Time of Death
Physicia ledical Exami	ner	David Houston	Hunt,Jr						S	Month Septembe	Day er 4, 2009		2236 hrs
		4a. Facility Name (if not institution Harbor Hospital Center		I number)		4b. City, Tov Baltimo		cation of	Death		4c. Co	unty of Deat N	th /A
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under Months	_	If Under Hours			,	1 0	irthplace (State or Foreign ountry)
Director		215-11-9183 Usual Residence of Decedent	1 XM 2	F 23	Yr		Days	Tiours	I. I.	March	10,19	86 Ba.	ltimore,MD.
w any	ı	10a. State 10b. County			Town or Loca								10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show 1 at once.	ctor	Maryland 10e. Street and Number	N/A	Ba.	ltimore	10f, Zip C	ode			1	0g. Citizen	of What Co	
the Ma sa or 28	Director	3548 Elmora Av	e.				212	13			Unit	ed Sta	ates
ath with tems 23	Funeral	11. Marital Status 1 X Never Married 2 M		Decedent Ever in U. d Forces?		as Decedent Yes, specify						Race - Ame White, etc.	erican Indian, Black,
after der al", or i	by Fu		orced If Yes, Give			Yes 2X						эслу:	hite
2 hours "natur		15. Decedent's Education (Spe Elementary/Secondary (0-12)		grade completed) ge (1-4 or 5+)	16a. Decede during r	nt's Usual O most of worki					16b. Kind	of Business	s/Industry
036 vithin 73 ene. er than	Completed	12		N/A		Un		oyed					ployed
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland near of Helath and Manell Hygient and use it filem 27 is marked other than "natural", or items 23a or 28a-f she wit if filem 27 is marked other than "natural", or items 23a or 28a-f she not other traumatic event, the Medical Examiner must be notified at once	Be Co	17. Father's Name (First, Middle David Houston					- 1		,	irst, Middle, ne Mac		name)	
212 should b nd Men is marl	2	19a. Informant's Name/Relations	hip (Type, Print)	3	•	(Street	and Numb	ber or Rur	al Route Nu	mber, City o		ite, Zip Code)
e, MD I and 2 sho Health and item 27 is		Donna Lynne Ma 20a. Method of Disposition			3548 Place of Dispo			etery,		Date	20c. Loca	yland ation - City	21213 or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If itel		1 Burial 2 Cremation 4 Donation 5 Other S		al from State EV	ans Fur	neral				09 ¹⁰ ,			ill,Maryland
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thin injury or other traumatic event, the Medi		21. Signature of Funeral Service	censee	ir, Dr.	22 Pe	Name and A Pacefu 2325 Y	ddress (f Facility tern	ative	es Fur imoniu	eral&	Crema	tion Ctr.,P.1 21093
Physician		23 / Part . Enler th - dir ease of ailure. List only one cau e	complications the	at caused the death	. Do not enter	the mode of	dying, s	uch as ca	ardiac or re	espiratory ar	rest, shock,	or heart	Approximate Interval Between Onset and
/Medical `xaminer		Immediate Cause (Final disease or condition resulting in death)	_{a.} Shotgur	wound (1) of	Chest and	Left Arm							Death
	Ļ	Sequentially list conditions, if any, leading to immediate bue to (or as a consequence of):											
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in t past 12 months?	he 1 L	ves, outcome of pregive birth	2 F	etal death	3	Ectopic	pregnanc	СУ		onth	Day Year
Box death c	nysic	1 Yes 2 No 9 Ur	known	regnant at time of de Inknown	eath 5 (Other (Speci	fy)						
5, P.O. BO) irres that the death is signed by the att d be detached for	by PI	Part II. Other significant condi	tions contributi	ng to death but not i	resulting in the	underlying (cause giv	ven in Pai	rt I.		tobacco use es 2 🗸 N		to the cause of death? robably 4 Unknown
ords, w require is been sig	Completed									24a. Wa	s an opsy	24b. Were	autopsy findings available to completion of cause of
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of Vital Reco ling Physician: The law After this certificate has funeral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2	FR/Outpatie		10	of Death (Other ₄	(Check on		Residence	e 6 Ot	her:
of V ing Phy After th	0 1 ✓ Yes 2 No 28 Date of Injury 28th Time of Injury 28th Injury at Work? 28d Describe how									occurred			
Sion Attend r death. ector: by the f	icatio	2 Accident Inve	estigation Sep	4, 2009 Place of Injury - At I	FOUND: 2215 hrs	reet, factory.		es 2 🗸	No			Number or	Rural Route Number, City
Division pital or Attencours after death erral Director: filled in by the	Certification:	4 Homicide dete	ild not be	cify) Local Stre					- 1	or Town, Im Tree St	State) reet and P	ennington	Avenue , Baltimore , Mi
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be- within 24 hours after death. To the Funerat Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical C	29a. Certifier 1 Certifying Fone) 2 Medical Ex	aminer:On/fie b	e best of my knowled asis of examination	dge, death occ and/or investig	curred at the gation, in my	time, dat opinion,	te and pla death oc	ace, and d curred at t	ue to the ca the time, dat	use(s) and r e and place	manner as s e, and due to	stated. the cause(s)
b Frith Company	Med	29b. Signature and title of certifi	/ and man	ner stated.			License	number			29d. Da	te signed (i	Month, Day, Year)
		//	/ (-				O.C.N	Л.Е. ———			Septe	ember 5,	2009
OCME		30. Name and address of person Mary G. Rippre MD.		cause of death (Iter ief Medical Exa	m 23a) iminer 1	11 Penn S	Street,	Baltim	ore, ME	21201		,	

State 31. Date filed (Month, Day, Year)
Registrar DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

		For State	State of M	laryland / I	•	artment of H		and M		/	nnc	28523	
		Registrar 1. Decedent's Name (First, Middle, L.	ast)		Cei	rtificate of l	Death		2. Date of Dea	th Day	Vaar	3. Time of Death	
Physicia /Medic		Louis E. Hof							Septemb	er 3,		12:42P M	
Examin	er	4a. Facility Name (If not institution, g		r)		4b. City, Town, or	r Location on onium	of Death		4c. Cou	inty of Deatl Balt		
Funeral		,	Sex 7. A	Age (In yrs. last bi	rthday)	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birt	thplace (State or Foreign ountry)	
Director		215-12-4765 Usual Residence of Decedent	1 X M 2 □ F	84	Yrs.	Month's Days	Tiodis	IVIII.	October	1,19	24 M	aryland	
/land		10a. State 10b. County		10c. City, Tow	n or Lo	cation						10d. Inside City Limits	
e Mary	Director	Md. Balto			Not	tingham						1 □Yes 2 No	
vith the		10e. Street and Number 4302 Soth Avenu	10			10f. Zip Code	1236			10g. Citizen		untry?	
eath v	Funeral	11. Marital Status	12. Was Deceden	nt Ever in U.S.	13.	Was Decedent of H		igin? (Spe	cifv Yes or No-	US.		erican Indian,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Exercity or other traumatic event events and the Modeal Exercity or other traumatic events are the Modeal Exercity or other traumatic events and the Modeal Exercity or other traumatic events are the Modeal Exercity or other traumatic events and the Modeal Exercity or other traumatic events are the Modeal Exercity or other traumatic events and the Modeal Exercity or other traumatic events are the Modeal Exercity or other traumatic events are the Modeal Exercity or other events and the Modeal Exercity or other events are the Modeal Ex	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 Xes 2	6?		lfYes, specify Cuba 1 □Yes 27 No	an, Mexicar Specify:	, Puerto P	Rican, etc.)	E	Black, White		
72 hou natura	eted	15. Decedent's 8	ducation		. Dece	dent's Usual Occup	ation	t of workin	na	16b. Kind o	f Business/	Industry	
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be file tal Hy d othe event,	Be	17. Father's Name (First, Middle, Las	,						(First, Middle,	Maiden Suri	name)		
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nd 2 sl lith an 27 is r r traur	ì	Ida Mae Hoffmei		ouse		2 SothAv			tinghar				
of Hea		20a. Method of Disposition		20b. Place	of Dispo	sition (Name of matory or other place	ce)	D	ate	20c. Location	on - City or	Town, State	
Page ment ant: If ury or		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		Park	aood	1		9-8-2			-	le,Md.	
permit. Depart Import any in]		21. Signature of Funeral Service Lice	ensee .	0 4	22	2. Name and Addre						ome d. 21236	
		23a. Part 1. Enter the disease, or co	nplications that caus	ed the death. Do	not en						.,	Approximate	
Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Due to (or as a consequence of):									Interval Between Onset and Death		
	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b											
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the Hospital or Attending Physician: The law requires that the death certificate be e hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician hipletely filled in by the funeral director, page 2 should be detached for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal deat t at time of death		☐ Ectopic pregnand ☐ Other (specify) _	СУ			23d.	. Date of de Month	elivery Day Year	
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Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpa	atient 2 ER/C	utpatie	nt 3 DOA Oth	205:				Other (Spe	ecify) HOSPICE	
nding Phy tth. :: After thi e funeral o	tion:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigati		njury 28b. <i>Day, Year)</i>	Time o	Wor	ryat rk?]Yes 2.⊑	.	28d. Describe h	now injury oc	curred		
al or Atte s after dek I Director d in by th	Certification:	3 Suicide 6 Could not determine		Injury - At home, f etc. <i>(Specify)</i>	arm, st	reet, factory, office			28f. Location (S City or Tov		umber or R	Bural Route Number,	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C		Physician: To the be aminer: On the basis tition er	s of examination a									
= 를 = 을	Me	29b. Signature and title of certifier	BERNA			29c. Licens	se number	1		29d. Date si	igned (Mon	th, Day, Year)	
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State

JACKIE JONES, CRNP
31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD. 32. Registrar's Signature

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 09 2009

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2, **Physician** 2009 8:55 P.M September Hav Dona1d /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore County Catonsville 148 Longview Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Sept. 29,1919 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F 89 Sept. Maryland Director 218-10-7117 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State d other than "natural", or items 23a or 28a-f show event, the "Adical Experience out to nother at 1 ☐ Yes 2 X No MD Catonsville Director **Baltimore** 10g. Citizen of What Country? 10e Street and Number 10f Zip Code filed within 72 hours after death with Hygiene. USA 21228 148 Longview Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: 1944–46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) . Pages 1 and 2 should be filed wit tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, Inc. Owner/Operator Gas Station 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Ray Frances Bryant George Morris Hay မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4243 Hermitage DRive; Ellicott City, MD 21042 Daughter Leslie Schinella Department of Health Important: If Item 27 any injury or other troonce. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 9/5/09 Woodlawn, Maryland Lorraine Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee MOIDSTO telema 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 Months Immediate Cause (Final disease or condition resulting in death) ONGESTIVE HEART **Physician** /Medical Due to (or as a consequence of): Examiner SCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 2 No 1 ☐ Yes 1 ☐ Yes : After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 12 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CATON ANE BALTIMORE MD 21229 31. Date filed (Month, Day, Year) State Registrar

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			For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of F rtificate of I			giene Reg. No.	09	28625					
			1. Decedent's Name (First, Middle, Las)				2. Date of Dea	Day	Year	3. Time of Death					
	Physicia /Medic		William Smith He	inekamp	_			Septe	mor 2	2009	2755 W					
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	ath	4c. County of							
			Seasons Hospice				11stown		Balt:							
В	Funeral Director		215-30-9142	X 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	Hours Mir		, Year) , 1933	Oount Mary	ace (State or Foreign ry) Land					
	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10	d. Inside City Limits					
	f sho	ō			Randalls						1 ☐ Yes 2 ☒ No					
	28a-	Director	Maryland Baltimor	-	Kandaris	10f. Zip Code			10g. Citizen of W	hat Count	ry?					
	3a or	<u></u>	4202 Deer Park	Road		21133			USA							
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Eventinar traist bu inclined at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🔀 No	lispanic Origin? (an, Mexican, Pue Specify:	(Specify Yes or No irto Rican, etc.)		- America k, White, et Whi	tc.					
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Ö	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	t time of death 5	Other (specify) _										
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Division of Vital	ding Phys After this funeral di	n: T	27. Manner of Death	28a. Date of Inju	ry 28b. Time				how injury occurre		/					
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Ö	tal or rs aft al Dii	Certification: To						1								
11	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical			of my knowledge, dea f examination and/or i ated.											
11	To the within To the Comp	Me	29b. Signature and title of certifier	R	1	29c. Licens	se number		29d. Date signed	(Month, I	Day, Year)					
			► KON KRULU	e Ben	ton	114	593		Septer	nbo	r 2,2009					
			30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	Print)		0 - 4 0 4	0 [. 1.	1-1	r 2,2009 n MD					
		200	W. Debbu	3 Burto	n 540	OLDO	COUNT	KO/HD /	candall	2 DON	n IVI					
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maa	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 2009 286										2862	
odia	Physical Exar			1. Decedent's Name (First, Middle,Last)				2	Date of Dea Month	Day Year	3	Time of Death 0215 hrs
euic	ai Exai	11111		Jamaal Calvin Holmes 4a. Facility Name (if not institution, give street and number)	4b. (City, Town, or L	ocation of I	Death	Septemb	er 4, 2009	Death	02151115
				University Hospital		Baltimore				n/a		
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	0W #0	. 1		10a. State 10b. County 10c. City, Town or Loci								0d. Inside City Limits
	ne Maryland or 28a-f show any	, ouc	흲	MD n/a I		timore of. Zip Code				10g. Citizen of Wha		
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	ier dez	i i	- 1	1 Yes 2 A No	Ye	s 2 X No	snecify:			Specify B.	lack	
	urs af		ğ	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	ent's L	Jsual Occupation	n (Give kin			16b. Kind of Busi		ustry
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MD 2	2 should th and Me 27 is ma	ı matic e	٦٩							mber, City or Town, MD 2		
	l and Healt Litem			20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or compared to the company of the			etery,		Date	20c. Location - C	ity or To	own, State
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Baltimore.	permit. Departn Imports	yolury.		1. Signature of Funeral Servicent I Insee 22. Jo	Name Ohn	e and Address of L. Wil	f Facility	Fu	neral	Directors timore,MI	Y 21	A.
Р	hysicia	n	\dashv	23a Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the m	node of dying, s	uch as card	diac or r	espiratory ar	rest, shock, or hear	212	Approximate Interval Between Onset and
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	F × 5	8	Ě	and manner stated. 29b. Signature and title of certifier		29c. License	number			29d. Date signed	(Month	, Day, Year)
				Theology W. K at JK. m. D.		O.C.M	l.E. 0	CME		September 4	I, 2009	9
			ŀ	30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner	11	1 Penn Stre	et, Baltii	more,	MD 2120)1	-	
		Sta		31. Date filed (Manth Pay Year) 2009 Service S. Aa	. 1	1						
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	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signat	ure	LLEY RD.	TIMONIUN	1, MU ZI	U 9 3	
Dui	Registr		SEP 0 9 2009	Denson	Ø.	par	Kel				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 2009 **Physician** 12:20 PM Logan Joseph Ingram /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery 13333 Waterside Circle Germantown Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Nov 20, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1**⊠** M 2□ F Months Hours Min. 1924 Georgia Director 050-18-5040 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show ?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Modical Examinating that he nother a 1 ☐ Yes 2 X No Director MD Montgomery Germantown the 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code with USA 20874 13333 Waterside Circle Funeral death v 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or iter 1 Never Married 2X Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1942–46 Specify: White 1 ☐ Yes 2 No Specify. 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Civil Engineer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Koullen Logan Leonidas Ingram 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13333 Waterside Circle Germantown, MD 20874 Marie G. Ingram/wife Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 09/09/09 | Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Puneral Service Dicer Gillig Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Liver Failure 48 hours /Medical Due to (or as a consequence of): Examiner Metastatic Prostate Cancer Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sels consequence of Examine spital or Attending Physician: The law requires that the death certificate be executed ious after death.

The law seems of the attending physician and reral Director: After this certificate has been signed by the attending physician and filled in by the funneral director, page 2 should be detached for use as the burdal-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 Coronary Artery Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypothyroidism autopsy performed? 1 ☐Yes 2 ☐No 1 ☐Yes 2 TyNo Nonulcer Dyspepsia 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1⊡Yes 2√∑No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D03519 September 8, 2009 8 + 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kevin M. Gil, M.D. 14816 Physicians Lane #253 Rockville, MD 20850 31. Date filed (Month, Day, Year) Registrar's Signatur State SEP 0 9 2000 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** 0,45 PM 0 an 01 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Grood Samanton Hos If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** Year) 1 □ M 2 😾 F 214-56-8853 62 27 NC Director 47 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It wellcal Examiner must be notified at 1 ☐ Yes 2 ☐Xio Director Middle River Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21220 2118 Graythorn Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: ≥ Black 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clothing Store Retail 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Davella E. Kittrell ပ္ Lee Bumpers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau 2118 Graythorn Road, Baltimore, Md 21220 Tyrone Cottrell-Son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet 9/8/09 Owings Mills, Md 4 Donation 5 Dother (Specify) 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21. Signature of Funeral Service Licenses Baltimore, Approximate Interval Between Onset and Death 23a. Part 1. Enter the of sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 10 candid disease or condition resulting in death) /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the a 2 XNo 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown this certificate has been s al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X** No 1 ∐Yes 2 ZiNo 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 🔀 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred al or Attending Patter death.

Director: After to be t 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paven Blud, Bultimore, MD 21239 DriRichouse 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 3,2009 John Francis Jackman September 4:44a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Hospital Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country)
Maryland 6. Sex Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**∑** M 2□ F 213-32-8194 74 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the "motical Examinar must be notified at 1 ☐ Yes 2 X No Director Baltimore Co. Dunda1k MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 USA 7416 Poplar Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 □Yes 2X No Specify. Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 8 Ň/A Floor Installer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Beatrice Sadie Neville Leo R. Jackman 9 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun <u> Patricia Jackman - Wife</u> 7416 Poplar Avenue Baltimore, MD 21224 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 9-4-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGESTIVE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner burial-transi and resulting in death) Last Due to (or as a consequence of): physician at the burial-Physician/Medical as IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy ō Month Year signed by the a 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I <u>ک</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 □Yes 2 🕅 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA ဥ After this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1KI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

72 hours after

be executed

Box 68760.

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of Vital Records,

Division

Hospital or

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

3901 The Alameda Baltimore, MD 21218 Amit Khosla 32. Registrar's Sig

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D57357

29d. Date signed (Month, Day, Year)

9-3-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month Day Year KORNELL KORCZYNSKI 2009 SCPT 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL CENTER WESTMINSTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Vrs. Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) 1**X**M 2□ F 88 MAY 8

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) **Physician** WILLIAM 10:24 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner CARROLL CARROLL Birthplace (State or Foreign Country) **Funeral** 219 05 0714 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No CARROLL Director MO WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RINGE ROAD 21157 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No PY5 If Yes, Give
Year or Dates: 1948 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BAKER 1-00D 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANDREW KORCZYNSKI SMULSKICH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CAROLANNE HOLNIKER 1732 RIDGE ROAD WESTMINSTERMO 21157 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ST MICHAELS 9-10-2009 DUNDALK, MO 4 Donation 5 Dother (Specify) 22. Name and Address of Facility JN ZUMBRUN FIT & MONCO. 21. Signature of Funeral Service Licensee 6028 SYKOVILLE RO ELDERS BURG MO 23a. Part1. Errier the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on unch line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 menta /Medical Due to (or as a consequence of) Examiner 1emmia Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed Ue.n Due to (or as a consequence of) Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ō in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2☐No 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s 2 No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) Stone 31. Date filed (Month, EP 09

State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 ar **Physician** Septmber Ada Grace Keefer 11:06pm M /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | July 4, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 D **Funeral** Months PA 218-24-9811 82 Director Usual Residence of Decedent the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State show ns 23a or 28a-f shormust be notified at MD 1 Yes 2 No Carroll Sykesville Director 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number death with 7701 A. Road 21784 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: "natural", or it 1 Never Married 2 Married 2 **X**No 2∏ No 1 □Yes Specify Specify: ò 3 Widowed 4 □ Divorced White Completed of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Gibson 0raပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Daughter) Ms. Linda Keefer 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ţ, Department of Important: If it any Injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem. Park 9- 9-09 Sykesville, MD 21. Signature of Funeral Service Licenses HAIGHT FUNERAL HOME & CHAPEL, P.A. M00764 PO Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of): the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Ulnknown 9 Unknown Be Completed by director, Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 ours after death neral Director: / filled in by the f 24 hours a within 24 hor To the Fune completely fi the

Baltimore, Maryland 21215-0036

Part II. Other sign i		ontributing to death but not resu		23e. Did tobacco us	se contribute to the cause of death?					
					24a. Was an autopsy performed? 1 □Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No				
25. Was case refe	rred to medical	-	26. Place of Death (Check only one)							
examiner?	1 00	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3 DOA	Other: 4 Nursing I	Home 5 ☐ Residence 6	Other (Specify) 405p1CC				
27. Manner of Dea 1 Matural 2 ☐ Accident	th 5 ☐ Pending investigatio	(Month, Day, Year)	28b. Time of Injury M	c. Injury at Work? 1 ∐Yes 2 ∐No	28d. Describe how injury	occurred				
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b determined	28e. Place of Injury - At hos building, etc. (Specify	me, farm, street, factory,	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only		nysician: To the best of my knowniner: On the basis of examinat								

State Registrar

Medical

29b. Signature and

29c. License number
29d. Date signed (Month, Day, Year)
29d. Date signed (Month, Day, Year)
29d. Date signed (Month, Day, Year)
21/4/09
3a) (Type Print)
25/dens burg, UMO 21784, Stevan Sillet, up

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	1	State Registrar					C	Certific	cate of	Deati	h		Reg. No.	20	1119	28633
		1. Decedent's Name	e (First, Middl	e, Last)								2. Date of De	eath Day		Year	3. Time of Death
Physicia /Medica		EL12	LABE	TH				KIL	LAN	1		SEPTEN			2009	0230 AM
Examine		4a. Facility Name (/	If not institution	n, give stree	t and number,)			City, Town,		n of Death	34	4c.	County	of Death	
		JOHNS HO	Aluns BA	YVIOW							MOIS					
Funeral Director		5. Social Security N 225–80–9	172	6. Sex 1 ☐ M		ge (In yrs.	last birtho	Mo	Inder 1 Year nths Days	_	er 24 Hrs. Min.	8. Date of Bi (Month, D 02/24)			9. Birth Cou	place (State or Foreign ntry) Ohio
pu	- 1	Usual Residence of 10a. State	f Decedent 10b. County			10c. Cit	v. Town o	r Location	1							10d. Inside City Limits
aryia sho	- 1	VA		erfiel	Ld		lothi								ļ	1 ∐Yes 2 XNo
be filed within 72 hours after death with the Maryland tital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Medical Evar fine must be notified at	ਙ∣	10e. Street and Nu 9741 Ben		ak Dri	ive			10	of. Zip Code 23112	2				zen of V JSA	What Cou	ntry?
hs 23a	era	11. Marital Status			Vas Decedent	Ever in U.	s.	13. Was I	Decedent of	Hispanic (Origin? (Sp	ecify Yes or N	0-			can Indian,
fter d	Funeral	1 ☐ Never Marr	ried 2 🔀 Mar	ried A	Armed Forces? ☐Yes 2	No						ecify Yes or No Rican, etc.)			ck, White,	
urs aff	<u>a</u>	3 Widowed			f Yes, Give /ear or Dates:			1 ⊔ Y	es 2.XINo	Speci	rty:			Specify	v: Wh:	ite
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ld be fillental Higher Ked ott	To Be	17. Father's Name George		Last)						Ann		endell	e, marden	Coman	10)	
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once.		19a. Informant's N				1						ral Route Num Midlot				
1 and Healt em 2		20a. Method of Dis		Call / I	Tabbane						-	Date				own, State
ages ent of it: If it	1	1 ☐ Burial 2 4 ☐ Donation	Cremation		oval from State	W.	emetery, Aru	cremator ndel	(Name of by or other pla Crema	tory	09/0	5/2009	Ode	ntor	ı, MC)
nit. F artm ortar injur	ł	21. Signature of Fi						22. Na	me and Add	ress of Fa	cility Re	ndon-Ba	iley	Fur	neral	Home, PA
Dep John any any any		plas	18.6	zin	MO	1452		2818	3 E. B	alti	nore	St., Ba	ltim	ore,	MD	21224
Physician		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition	art failure. Lis (Final	r complication	ause on each	ed the deat line.			e mode of dy			or respiratory	arrest,			Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death))		Due to (or a		- 7 7									
ed sit	iner	Sequentially list co if any, leading to in cause. Enter Und	onditions, mmediate erlying	Į b. —	Due to (or a	s a conseq	quence of):								
executed n and ial-transit	Examiner	Cause (Disease or that initiated event resulting in death)	ts	c	Due to (or a	s a conseq	quence of):								
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that the ed by detac	Ph	Part II. Other signi		ions contrib	uting to death	but not res	sulting in t	the underl	ying cause g	given in Pa	art I.	23e. Dio	tobacco	use con	tribute to	the cause of death?
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e law requir has been s je 2 should	nplet								_			24a. Wa	topsy	24b.	prior to c	topsy findings available completion of cause of
sician: The l certificate ha rector, page	5											1 □ Yes	formed?		death? 1 ☐ Yes	2 🗆 No
Physician: this certifical	Be	25. Was case refe examiner?	erred to medica	-							ace of Dea	th (Check only	y one)			
Ø :2: ₹	၉	1 Yes 2 €		Hosp	1 ∐ Inpa	tient 2 🗹			L DOA		Nursing H	lome 5 Re				cify)
ling F	ion	27. Manner of Dea 1 Natural	5 Pendi	ng	28a. Date of In (Month, D		28b. Tii Inj	ury		jury at ′ork? ∐Yes 2	. □No	28d. Describe	e now inju	ry occui	rreu	
ttend death ttor:	icat	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could		28e. Place of I	niury - At h	ome farr				. []]NO	28f Location	(Street a	nd Num	her or Ru	ıral Route Number,
after of Direct of in by	Certification: To	4 Homicide	deter	mined 6	building,	etc. (Speci	ify)	n, street,	iactory, omo	5			own, State			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, in the funeral director, in the funeral director, in the f	Medical C	29a. Certifier (Check only one)	1 Certify 2 Medica	ing Physici i Examiner	an: To the bes On the basis and manner:	of examin	owledge, ation and	death oc	curred at the	time, dat y opinion,	e and place death occu	e, and due to the	he cause(s ie, date an	s) and n	nanner as , and due	s stated. to the cause(s)
To the within 2 To the comple	Me	29b. Signature and	2	er nd-	710	vez				ense numb	72		29d. Da	ate sign	ed (Monti	h, Day, Year) 109
		30. Name and add	dress of persor	n who comp	leted cause of	death (Ite	m 23a) (1	Type, Prin	t)							
11		mo:	STAFA	FRA	ara n	nb	4	940	EAS	15121	Ave	ENVE 1	BALT	ne	NE V	nd 21224
Sta		31. Date filed (Mo.	SEP (32. Reg	trar s Sign	ature	16	es plas						,	nd 21224
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Glenn Edward Kendrick Certificate of Death 1- For State Reg. No. Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Month Day September 5, 2009 Physician/ 0800 hrs Glenn Edward Kendrick Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Towson Saint Joseph's Hospital 9. Birthplace (State or Foreign Country) TOWSON, 8. Date of Birth (MM/DD/YYYY) If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** December 31, 1980 Days Months Hours 218-96-1337 Maryland 28 Director 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location 1 Yes 2 No 10a, State 10b. County Ξ unk. unk. 23a or 28a-f show notified at once. unk. death with the Maryland 10g. Citizen of What Country? United States Director 10f. Zip Code 10e. Street and Number unk. America unk. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. must be Armed Forces? 1 Never Married 2 X Married Yes white Yes 2 X No specify: Yes, Give Yea Pages 1 and 2 should be filed within 72 hours after tment of Health and Mental Hygiene.
 rtant: If item 27 is marked other than "natural", o 4 Divorced Widowed item 27 is marked other than "natural", traumatic event, the Medical Examiner þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) unemployed unemployed 21215-0036 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carol Lorraine Forenski Robert Glenn Kendrick Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 19a, Informant's Name/Relationship (Type, Print) 3 Warren Lodge Court Cockeysville, Maryland Robert G. Kendrick/ father Itimore, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Sept. 9, Du frametery or other place) 1 XXBurial 2 Cremation 3 Removal from State Timonium, Maryland 2009 Memorial Gardens Donation 5 Other Specify: 22. Name and Address of Facility Peaceful Alternatives Funeral &Cremation Ctr., P. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee 23a. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line /Medical aAlcohol and narcotic intoxication and cocaine use Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed 23a,27,28a-f,perME, g895 9/15/09 TT Physician/Medical AMENDED X UNPENDED ned by the attending physician detached for use as the burial -Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year Day Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Linknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown has been signed be 2 should be deta ò 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of autopsy performed? death? certificate has 1 🗸 Yes ✓ Yes 2 No page 26 Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: director, Division of Vital Be Hospital: 1 examiner? Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 this 1 🗸 Yes 2 No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: Yes 2X No 1 Natural Pending 24 hours after death. Director: Fd 9/5/09 Fd 7:12 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify)

At home, farm, street, factory, office building, etc.

Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

305 E. joppa Rd

Towson, MD 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide To the Funeral Di Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 6, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

32. Registrar's Signature

31. Date filed (Month, Day, Year

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month Physician 09 30 AM 2009 09 4a. Facility Name (If not institution, give street and number) 04 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner inian memorial If Under 1 Year | If Under 24 Hrs. mo 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Months 1 □ M 2 🔭 F 9 Yrs. 216096481 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shot injury or other traumatic event, the "hodical Examiner injust to no tiffed at 1 Yes 2 No Director MIN BATTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5404 GARden wood 21206 U.S.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Specify: B/ALK δ % Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. POSTA. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If Item 27 is marked other th, any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rie GARden Wood Timore MARUANG Date 20c. Location City or Town/State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signatury of Fury ral Service Licensee 22. Name and Address of Facility unena 1MD,2P1 CAROSINE 1129N1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal years /Medical Due to (or as a consequence of): Examiner Jear Congestive Sequentially list conditions, if any, reading to finine dialocause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hypertensive burial-trar Due to (or as a consequence of): weeks Physician/Medical Stroke the SS IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown signed of be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Ť. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 → npatient 2 □ ER/Outpatient 3 □ DOA filled in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Box 68760, Records, P.O.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Division of Vital

To the within 5 To the Comple	Mec
Sta	
Regist	ar

Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 09/04/09 AT2 43 2946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

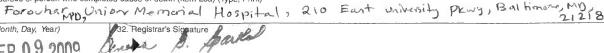
28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year)

2 Accident 3 Suicide

4 Homicide

6 ☐ Could not be



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State of Maryland / Department of Health and Mental Hygiene

		-	For State of Marylan		•	rificate of L			Reg. No.	3 111 6	20000
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea 09-07-		y Year	3. Time of Death
	/Medic	al	Hazel J. Kitson 4a. Facility Name (If not institution, give street and number)	_		4h City Town or	Location of Death	09-07-		County of Death	
	Examin	er	514 Red Pump Rd			Bel Air				Harford	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 1 M 2 7 F 80		hday) (rs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Date 06-20-	th y, Year) 1929	9. Birth Cou	nplace (State or Foreign Intry) MD
	D .		Usual Residence of Decedent	T.							10d. Inside City Limits
	show	'n	10a. State 10b. County 10c. Ci								1 □Yes 2 ☑ No
	the M	Director	MD Harford 10e. Street and Number	Be	1 A:	10f. Zip Code			10g. Cit	izen of What Co	
	3a or	io le	514 Red Pump Rd			2101	. 4		US	SA	
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	S.	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Amer Black, White	
215-0036	hin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Medien Evanther must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No 3 🛱 Widowed 4 ☐ Divorced 1 ☐ Yes, Give Year or Dates:				Specify:				White
<u>ဂ</u>	72 hc "natur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decede	ent's Usual Occupa	ation furing most of work ')	ing	16b. K	ind of Business/I	ndustry
7.	£ e ₹ M	duic	Elementary/Secondary (0-12) College (1-4or 5+)	Но		naker)		Ow	n Home	
פר	be filed that Hygin of other event, I	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name			Surname)	
yland	e 6 5 5	TO E	Harry W. Fox				Hazel M	. Cooks	ey		
Mar	CJ 10		19a. Informant's Name/Relationship (Type. Print)	- 1			and Number or Run				ip Code)
	1 and Healtt em 27 ether t		William Fox (Nephew) 20a. Method of Disposition 20b.			Red Pump ition (Name of atory or other plac		Air, MD		ocation - City or	Fown, State
JOE L			1 Burial 2 Existentiation 3 Li Removal from State			atory or other plac rematory		8-2009	Balt	imore,	MD
Baltimore,	permit. Page Department of Important: If any injury or once.	Ĭ	21. Signature of Funeral Service Licensee	120		-		1			e of BelAir
<u>n</u>	8 3 E 8		Diano Jose		In	c 610 W.	MacPhail	Rd Bel	Air,	, MD 210	14
			23a. Part1. Enter the disease, or complications that caused the dear shock, or heart failure. List only one cause on each line.	th. Dor	not ente	2		or respiratory a	rrest,		Approximate Interval Between Onset and Death
mar.	Physician /Medical	ľ	Immediate Cause (Final disease or condition resulting in death) Due to (or as a co sec	Juanca	y the	1	ene				
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	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	_		Vascul	10.	1500			
	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consec	Lence of	of):	Masivi	iar L	1/36631			
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89		fedical	U								
X P P	eath cert attending for use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fet	al death		Ectopic pregnanc	у			23d. Date of del	ivery Day Year
o	requires that the death cer been signed by the attendir hould be detached for use	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of 9 ☐ Unknown	death	5 □	Other (specify)	<u> </u>				
٠ <u>.</u>	w requires that the de been signed by the should be detached i		Part II. Other significant conditions contributing to death but not res	sulting in	the un	derlying cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
g	equires en sigi	ed by	Hyperlipidemia					1 🗆	Yes 2	No 3□Pi	obably 4 Unknown
Hecords,	law as b 2 sl	Completed	Hypertension					24a. Was	psy	prior to	topsy findings available completion of cause of
r m	sician: The law certificate has b rector, page 2 sl	Con						perfo 1 ☐ Yes	ormed? 2 □ N	death? 1 □ Yes	2 □No
VItal	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	1 == /0		Oth	er:			s = 01 - 10	
ō	ttending Physical death. ctor: After this of the funeral directions of the funeral directions.	n: To	1 ☐ Yes 2 ☐ No ☐ ITOSpitati. 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	28b.	Time of	28c. Injur Worl	y at	28d. Describe		6 ☐Other (Spe iry occurred	cny)
0	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation		njury		Yes 2 □No				
Division	or Atter fter de directe	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At houilding, etc. (Spec	iome, fa ify)	rm, stre	et, factory, office		28f. Location (City or To	Street a wn, Stat	nd Number or Ri e)	ural Route Number,
<u> </u>	spital ours a leral C		29a. Certifier 1 ☐ Certifying Physician: To the best of my kn	owledge	e, death	occurred at the ti	me, date and place	, and due to the	e cause(s) and manner a	s stated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examiner: On the basis of examin one) and manner stated.	ation ar	id/or inv	restigation, in my o	ppinion, death occu	rred at the time	, date an	nd place, and due	to the cause(s)
	Vithii To th	Ž	29b. Signature and title of certifier			29c. Licens	e number		29d. Da	ate signed (Mont	h, Day, Year)
			Makes 1 Fg and			D3	0/32		07	1001	2004
_	101		30. Name and address of person who completed cause of death (Ite Robert S. Knight, MD 1041)	m 23a)	(Type, F	Road Su	ite 102	Bel ,	Air	Man	land 21015
ľ	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Sign	ature		1 0 2	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, , ,	. ,		h, Day, Year) 2009 aud 21015
	Registr	ar	SEP 0 9 2000 Jensus	19.	1	acker					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** KATZEN 3 2000 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Levindale Hebrew Center Baltimore Year | If Under If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 12M 2□ F Months Days Hours 192-30-1757 68 October 25, 1940 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Owings Mills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 Bucksway Road United States 21117 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygene. Important; If fem 27 is marked other than "natural", or lite any Injury or other traumatte event, the Medical Examine any Injury or other traumatte event, the Medical Examine 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Attomey 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hyman Milton Katzen 2 Mary Korein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jean Katzen/Wife 9 Bucksway Road, Owings Mills, Maryland 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 4. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State natory, Inc. 2009 Baltimore, Maryland
22. Name and Address of Facility Cremation Society of Maryland, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signatura of Funginal Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COMPLICATIONS OF PERIPHERAL VASCULAR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DISCHISE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine MELLITUS 13 ABGTES attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERY DISCHEE CORONANY 1 Yes 2 No 3 Probably 4 Unknown Completed COMMESTIVE HUMAT 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe 13 EMENTIA 1□ Yes 2☑No 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1. Natural 1 Tyes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 📭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier PHYSICIAN D0064533 09-04-2009

10 V

State Registrar BABATUNDE AJANI MD 2434 W. SELVEDERE
31. Date filed (Month, Pay Year)
SEP 09 2009 Kenne B. Sand

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEVINDALE CICRIATRIC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 3:20 AM **Physician** 2009 Sr. Η. Lam Charles /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name*(If not institution, give street and number) POSCOME

If Under 1 Year | If Under 24 Hrs.

Days | Hours | Min. Examiner Baltimore Franklin Sauare Hospital 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 **X**M 2 ☐ F 85 Virginia October 28,1923 224-26-4116 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Baltimore Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 7831 Deboy Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Container Manufacturer Machine Operator 6 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucy Jenkins Hezekiah Lam ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7831 Deboy Avenue, Dundalk, Maryland Agnes M. Lam wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) September 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Rosedale, Maryland Gardens of Faith 10, 2009 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee connelly funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the dearn Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DNOVINONIA Week Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate in Inder in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 2 Fetal death Month Day in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Miun COYONANY 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No has certificate 10 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 21 No 2 ER/Outpatient 3 DOA P 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death : After 1 Certification: (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Sulcide 4 ☐ Homicide completely filled

The law requires that the death certificate be executed Box 68760. Division or Vital Records, P.O.

Maryland 21215-0036

Baltimore,

within 24 hours after death To the Funeral Director: or A Fo the Hospital

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Majid Cina,

31. Date filed (Moor Lay,

200

M.D.,

30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

9000 Franklin Square Drive,

32 Registrar's Signatu

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D63054

Baltimore,

29d. Date signed (Month, Day, Year)

eptember 7, 2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 10:30 a Alice Mary Lucas Sep 5, 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Randallstown Seasons Hospice of Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1 □ M 2 🖫 F Months Director Oct 23, 1919 Maryland 214-40-7008 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventual Description at another. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21223 1120 West Franklin Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. þ Specify: 3 □ vidowed 4 □ Divorced Black Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Baltimore City Schools** Custodian 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Burgess Norris Joyce 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1120 West Franklin Street Baltimore, Maryland 21223 Phyllis Parker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 09/12/09 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Western Star Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P.A 1300 Eutaw Place Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphock/of heart failure. List only one cause on each line. Immediate Cause (Final adeno carcinoma (un known priman Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical the, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Month Year signed by the ar 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Conknown Completed Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 ☐ Yes 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this : After thi 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Kayapakishin D D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) suite 200, Reisterstown, MD. 21/36 Raj apakse, M.D. St. 25 Main

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 ก็ว้ 2009 11:40 PM Edward Donald Lassahn, Sr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Maryland Gilchrist Center Towson, 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 1 **K** M 2 □ F Months Hours 1472971923 Maryland 85 212-20-7212 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 🄀 No MD Harford Bel Air 10f. Zip Code 10q. Citizen of What Country? 10e Street and Numbe 21014 U.S.A. 102 Nichols Street Unit 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married If Yes, Give WW II 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) AT&T <u>Mechanical Engineer</u> 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian V. Kaiser Louis Carl Lassahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Nichols Street - Unit 2 - Bel Air, MD 21014 Grace Lassahn (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Timonium, Maryland Dulaney Valley Mem. 109/05/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland as 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): that initiated events Due to (or as a consequence of): resulting in death) Last 23d. Date of delivery Month Day Year 26. Place of Death (Check

Physician/ Medical **Examiner** attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed

Physician/

Medical

Examiner

Funeral

Director

28a-f shor

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items 23a

o.

"natural"

and Mental Hygiene.

permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt once.

must be notified

Director

Funeral

Completed by

Be

with the Maryland

5-0036

Maryland 2121

Baltimore,

Division of Vital Records, P.O. Box 68760

40

Completed by Physician/Medical B B |은

been signed by the a should be detached

this certificate has ral director, page 2

24 hours

within 2 To the F

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)	
Part II. Other significant condition	s contributing to death but not resulting in	the underlying cause given in Part I.	23e. D

	23e. Did tobacco us	e contribute to the cause of death?
	1 🗌 Yes 2	No 3 Probably 4 Unknown
	24a. Was an autopsy performed? 1 ☐ Yes 2 🗡 No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
on	ly one)	

examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital:
27. Manner of Death	28a
1 Natural 5 Pending 2 Accident Investigation	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e 28e.

pitai.	1 Inpatient	2 🗆	ER/Outpatient	з 🗆	DOA
28a.	Date of injury (Month, Day, Ye	ar)	28b. Time of injury	М	28c
28e.	Place of Injury -	At ho	me, farm, stree	t, facto	ory, o

ce o	e of Death (Orieck offly Orie)							
r: 4	☐ Nursing H	ome	5 Residence	6	Other	(Specify)	HOSP	14
at			Describe how inj	_			_	
/es	2 No							

29a.	Certifier	1. Certifying Physician: To the best of my knowledge, death occu	red at the time, date and place, and due to the o	cause(s) and manner as stated.
	(Check	2 Medical Examiner: On the basis of examination and/or investigation	on, in my opinion, death occurred at the time, date	and place, and due to the cause(s
	only one)	3 Certifying Nurse Practioner: To the best of my knowledge, death	occurred at the time, date and place, and due to	the cause(s) and manner as stated
29b.	Signature an	nd title of certifier	29c. License number	29d. Date signed (Month, Day,

et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	r und due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s) and manner stated.

	only one,	3 Li Certifying	Nurse Fractioner.	To the best of my	Kilowieuge
29b.	Signature	and title of certifier		7	
		1	20	01	~
					00 \ (T

	nber	ense nui	29c. Li
95	30	604	D

Othe

28c. Injury

SEPTEMBER 2,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEUE DOBERMAN, MD 6701 N CHARLES ST, SWITE 4105 BALTIMORE, MD 21204 31. Date filed (Month, Day, Year)

State Registrar

Medical (



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2864 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Maddox ucille 12:20 AM Virginia September 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sinar Hospital of Baltimore Balti Mose Cite Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 2 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 **X** F MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 273 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, he bedies Examine must be notified as Baltimore MD Kandallstown 1 □Yes 2 XNo Director 10g. Citizen of What Country? 10e. Street and Number 3530 Desource Drive Apt. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 13 lack Specify: ≥ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Processor Westin ahouse 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence GODUVA 19b. Mailing Address (Street and Number of Rural Route Number, City r Town, State, Zip Code) 21208 19a. Informant's Name/Relationship (Type. Print) Dennis Gobur 7211 Chalkstone Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Laurel, MD 09/12/09 Maryland National Vauxon C. Greene Funeral Services 21. Signature of Funeral Service Licensee

22. Name and Address of Facility Vaurahn (. G

8728 Liberty Road Bandall

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility Road Randallstown MD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute **Physician** 8es 1801084 /Medical Due to (or as a consequence of): Examiner 29day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to fur as a contequence of Examine burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Hybertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen s Cerebral Vasculari Accident 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☑No To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certified 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Nertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier nut kapas 19620 96 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V

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31. Date filed (Month, Day, Year) SEP 0 9 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Day **Physician** Bertha Mge MCFall 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltin Northwest Hospice landallstown Slasons Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 X F Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 XNo Baltimore Keisterstown MD **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number items 23a or 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married o. Specify: Back 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced "natural", Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, Its Meanging once. College (1-4or 5+ Elementary/Secondary (0-12) Baltimore Citi Worker ocial 12th grade 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be (Pauley Edward Rhodes stella 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6203 19a. Informant's Name/Relationship (Type, Print) 673 Shadow Rock Drive Florissant Mo NCFall Timothy 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Woodlawn, MD Woodlawn Cemetery 12/09 22. Name and Address of Facility Vaugon C. Greene Funeral SVCs 21. Signature of Funeral Service Licenses iberty Road Randalistown MD 21133 8728 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as lardiac or respiratory arrest, shock, or heart filture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Metastatic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
PA hours after death.
Funeral Director: After this certificate has been signed by the attending physician and physician and the burial-tran Due to (or as a consequence of) Physician/Medical attending p for use as 1 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2⊠No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 9 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

SEP

Saltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

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۱	Physicia		1. Decedent's Name (First, Middle, Last) 2. Date of Death HENRY M. MCCLOSKEY SEPTEMBER						3. Time of Death 1:30 ам	
/Medica Examine			4. English Name (If and Institution of material and assertion of Dog					4c. County of Death BALTIMORE		
	Funeral Director	ctor	5. Social Security Number 217244326 0. Sex 1 M 2 □ F 0. Age (In yrs. last.) 80 Usual Residence of Decedent	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01/24/	Year) 9. Birthp Court 1929 MARS	place (State or Foreign ntry) LAND	
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ylan	2 should be and Mental is marked o		SIMON McCLOSKEY			ELISAI		UNK.	- 2-41	
Baitimore, Maryland 21215-0036	5世紀		19a. Informant's Name/Relationship (Type. Print) BEVERLY A. McCLOSKEY/WIFE					; City or Town, State, Zip D, MD 2104		
	t. Pages tment o tant; If		1 Rurial 2 Cremation 3 Removal from State	otery, cren	sition (Name of natory or other place REMATOR)	7 09/0	09/09 1	20c. Location - City or To BALTIMORE, EDALE FUNI	, MD	
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	Physician /Medical Examiner		23a. Part 1. Enter the disea of the complications that caused the death. Description is shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) LUNG CANCER Due to (or as a consequence)		er the mode of dyn	ig, such as calulat	or respiratory am		Interval Between Onset and Death	
		Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Luisease un mun y	ce of):						
	cate be executed physician and the burial-transit		that initiated events resulting in death) Last C	ce of):						
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of Vi	Physic this ce al direc	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER	Outpatier		er: 4 🗌 Nursing H	lome 5 Reside	ence 6 COther (Speci	fy) HOSPICE	
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Division	al or Att		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)			eet and Number or Rural Route Number, State)				
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) X Nurse Practitionary stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	To the within 2 To the complete	Σ	29b. Signature and title of certifier JULISH 1		29c. Licens	9792	_ 2	9d. Date signed (Month,	Day, Year)	
	5 V		30. Name and of diss 1 person who completed cause of death (Item 23 JACKIE JONES CRNP 2300 DULANEY	VAL		TIMONIUM	, MD 210	93		
State 31. Date filed (Month, Day, Year) Registrar SEP 0 9 2009 33. Registrar's Signature										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 4:32 P M August Miller 30 2009 Virginia Mae /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Heartfields Assisted Living Frederick If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2**X** F Director 578-28-9462 84 30, 1924 Ohio Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int. If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Frederick Union Bridge 10g. Citizen of What Country? 10e. Street and Number 10610 Renner Rd. 21791 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 XNo Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ☑No Specify: Specify: ģ 3 XWidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louise L. Liskey Charles Edward Long 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. Karen L. Sindt/daughter 7337 Brown Bridge Rd. Fulton, MD 20759 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/2/2009 Rocky Hill Cemetery 4 Donation 5 Other (Specify) nr. Woodsboro, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home Jarine LIbertytown, MD 21762 11802 Liberty Rd. 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** and 10 myotal disease or condition resulting in death) /Medical Due to (or as a consequenc of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 1 □Yes 2 ☑No 1 ☐ Yes of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) assisted living Hospital: Other: 4 Nursing Home 5 Residence 6 other (Specify) 1 | Yes 2 | 1√0 Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred **Division** 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signat e and title of certifier 29c. License number D60417

Registrar

State

Thomas

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Shah

SEP 0 9 2000

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death 1415 hrs			
ledical Exami	ner	Jason Thomas May 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Month September	2, 2009 4c. County of Deat				
		306 Nancy Avenue Linthicum Heights		Anne Arunde				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 219-06-5033 1 X M 2 F 32 Yrs. Months Days Hours Min.		(MM/DD/YYYY) 9. Bi Forei Co				
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ath wif	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin?)	Rican, etc.)	White, etc.	rican Indian, Black,			
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21215-0036 build be filed within 7 Mental Hygiene. marked other than c event, the Medica		17. Father's Name (First, Middle, Last) 18.Mother's Name						
121 d be fi fental l narked event,	o Be	Jeffrey May Vickie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I	e Gary	her City or Town Stat	e Zin Code\			
MD 2 nd 2 shoul aith and M m 27 is n aumatic	۲	Mrs. Vickie Yeager (Mother) 306 Nancy Ave., Lint		-	c, zip codc)			
re, N l and l Health f item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of				
Pages Pages nent of ant: 1 or oth		4 Donation 5 Other Specify: Lake View Mem. Park 9/6	8/2009	Sykesvill	e, MD			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical		21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOI PO Box 195 Sykesy	ille. MD	1 21/04				
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delive Month	Day Year			
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Division of Vital Records, tal or Attending Physician: The law requirers after death.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S or Town, S		Rural Route Number, Cit			
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	51 1298 Centiler a last a							
N 5 4 5 0	Medical	29b. Signature and title of certifier 29c. License number		29d. Date signed (A				
		MM C DP O.C.M.E.		September 3, 2	2009			
		30. Name and address of person who completed cause of death (Item 23a)	4D 04004					
		Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, Modified (Month, Day, Year) 32 Registrar's Signature	21201 טוי					
St Regis								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Month 8:35p Marvin Gene Mahan September 6, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Colora Cecil 24 Love Run Road If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**⅓**M 2□F Months Davs Hours 218-28-2869 17, Maryland Director 77 1931 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director Cecil Colora 1 ☐ Yes 2 🕱 No Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 24 Love Run Road USA 21917 Funeral 12. Was Decedent Ever in U.S.

1 Armed Forces?

1 DYes 2 □ No
If Yes, Give
Year or Dates: 1951–1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, within 72 hours after 1 ☐ Never Married 2 → Married Baltimore, Maryland 21215-0036 1 □Yes 2 No þ Specify. white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is 1 and 2 should be filed withi.
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Item 27 is marked other than civil service US Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic ev Leroy Mahan Myrtle Stearn ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Love Run Rd., Colora, MD 21917 Shirley J. Mahan (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of I 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 9/10/09 Havre de Grace, Maryland Rock Run Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cargo Funeral Home, P.A. -3399 Tarring-C Aberdeen, Maryland 21001uster 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician disease or condition resulting in death) ROLUS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to him editing cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last que to for es a porsequence offi-Exami requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Year 5 Other (specify) P.O. the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been siç ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate □Yes 2□No 1 ☐ Yes 2 **N**o 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signatu re and title of certiff 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROMIL 155 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 09 Registrar

09-06922 John Miller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			- For State Certif	icate of Death	Reg. No	. 0 0 3
	Physicia	_	1. Decedent's Name (First, Middle,Last)		Date of Death Month Day Year 3. Time of D	
Med	dical Examin	ner	John Miller		September 4, 2009 2000 11	rs
			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	
			3911 Rokeby Road	Baltimore 15 June 2011 Jun	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State	9.00
	Funeral	1	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	Foreign	
	Director	L	217-54-4705 1VM 2 = 5	9 9 Yrs.	6-8-1950 Country) N	0
	<u> </u>		Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location	10d. Inside	City Limits
	ow any			4	1 Yes	2 No
5	yland I-f sh	휘	10e. Street and Number	1timore 10f. Zip Code	10g. Citizen of What Country?	
	Mar r 28a	<u>ē</u>	2211211	2/226	USA	
	ith the 23a c	計	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe-	01 377	Black,
	ath w items	Funeral Director	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto R		
	her de		Widowed 4 Divorced If Yes, Give Year 1968	1 Yes 2 No specify:	Specify: Black	
	nurs af Itural amin	d by		6a. Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retire	ork done 16b. Kind of Business/Industry	
	72 hc	ete.	Elementary/Secondary (0-12) College (1-4 or 5+)	auring most of working me. Do No Fuse reare		./
	5-0036 led within 7. Hygiene. lother than the Medical	Completed	/JEE	Clerk	Social Sect	UCITY
	ID 21215-00; should be filed with and Mental Hygiene ?? is marked other thatic event, the Men		17. Father's Name (First, Middle, Last)	18.Mothers Name (First, Middle, Maiden Surname)	
	2121; hould be fill and Mental Is is marked tric event, i	B	19a. Informant's Name/Relationship (Type, Print)	19h Mailing Address (Street and Number or Ru	ural Route Number, City or Town, State, Zip Code)	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Opparmment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	٩	Juan ali Hadith Son	7950 Jersey Rd	Sa lishurumDa18	01
	re, ME s 1 and 2 s of Health an If item 27 ner traums	1	20a. Method of Disposition 20b. Pla	ice of Disposition (Name of cemeter),	Date 20c. Location - City or Town, State	
	Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2		Burial 2 Cremation 3 Removal Itom State	ematory or other place)	16-09 Privace Mills	mi
	Baltimosermit. Pag Department Important:	1	4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee	22. Name and Address of Facility 4 vg	hn C. Greene Foneral Ser	vices
	Balti permit. Departr Import injury		Vancha C. Streen	5151 Ba Ho. Nat	1 Pike Balto. MD a	1229
	Physician		23a. Part I. Ener the disease, or complications that caused the death. D		respiratory arrest, shock, or heart Approxim Between	nate Interval Onset and
	/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Narcotic intox:	ication		eath
*	`xaminer		or condition resulting in death) Due to (or as a consequence of):			- 1
		ايا	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
		Examiner	if any, leading to immediate Cuse Enter Underlying Course (Disease or injury that initiated			
	sit d	xar	events resulting in death) Last Due to (or as a consequence of):			
	760, icate be executed physician and the burial - transit		d23a, 27, 28	8a-f,permE, g896 10/2/0)9 TT	
	760, icate be ex physician the burial	Medical			23d. Date of delivery	
	3760 ficate b g physical s the bu	~	## FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnant in the 1 Live birth	ancy 2 Fetal death 3 Ectopic pregnar		Year
	Box 687 c death certifi the attending ed for use as t	ia is	past 12 months?			
	Bo e deat the at	Physician	1 Yes 2 No 9 Unknown 9 Unknown			-f -tt0
	O. hat th ed by letach	by P	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of 1 Yes 2 ✓ No 3 Probably 4	
	S, P nires t n sign d be c				24a. Was an 24b. Were autopsy finding	
	w requisions peculon	Completed			autopsy prior to completion of death?	
	Reco	E				No
	al Fian:	യ	25. Was case referred to medical examiner?	26.Place of Death (Check of		
	Vit hysic this c	To B	1 Yes 2 No Inpatient 2 E		g Home 5 Residence 6 🗸 Other: Scene	
	Division of Vital Records, P.O. rate of a vital and that the safer death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac.		(Month, Day, Year)	, ,	28d. Describe how injury occurred ${ m unk}$	
	Sior ottend death ctor: y the	atic	Accident Investigation Fd 9/4/09	Fd 8:15 pm 1		Jumber City
	ivis	Certification:	3 Suicide 6 X Could not be determined (Specify) hou	ne, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Nor Town, State) 3911 Rokeby R Baltimore, MD	ď
	ospita hours inera y fille		4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge			
	Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi- within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t	ical	one) 2 Medical Examiner: On the basis of examination an	d/or investigation, in my opinion, death occurred a	t the time, date and place, and due to the cause(s)	
	To To com	Medical	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Ye	ear)
		1272	Menza To Me Coline	O.C.M.E.	September 5, 2009	
		#	30. Name and address of person who completed cause of death (Item:	23a)		
F	OK ser	0	Margarita Korell MD. Assistant Medical Examine		21201	3
0	gant					
G	/	tate		Sares		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 29,2009 6:13 P McArthur August Leroy Michael /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Montgomery Silver Spring Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 5. Social Security Number **Funeral** Days Hours Min XXM 2□F 46 Washington DC Yrs January 10,1963 571-82-2094 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the redical Examinating must be 13 different. XXYes 2□No Director District of Columbia Washington 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 20032 United States Apt 202 136 Ivanhoe St SW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Park Service Eleventh. None Landscaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Luke McArthur Nancy Foutz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 136 Ivanhoe St SW #202, Washington DC 20032 Luke McArthur/Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 5 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National 2009 Suitland, Maryland 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 1661 Good Hope rd SE, Washington DC 20020 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Hypertension disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Peripheral Edema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami burial-tran and Due to (or as a consequence of) physician a Box 68760. pe Physician/Medical attending pl IF FEMALE: nse. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy law requires that the death Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a detached f Ö 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐Yes 21K No certificate 1 □Yes 2X No or Attending Physician: After this certification, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No 1 Inpatient 2

ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. ours after death. 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

5 V

John McNeil M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

SEP 0 9 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

ORIGINAL

13975 Connecticut Ave, Silver Spring, MD 20906

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Ruth Markins 200 Deptember /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Samoritan HOSDITAL Baltimore If Under 1 Year | If Under 24 H 9. Birthplace (State or Foreign Date of Birth (Month, Day, 5. Social Security Number (In yrs. last birthday) **Funeral** Year) Min Months 1 □ M 2 🔼 F West Virginia 234-82-8754 Yrs 04/04 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County er than "natural", or items 23a or 28a-f show the Medical Examinar rust be rediffed at 1 ☐ Yes 2 No ackville MD Parkville Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21234 USA ount Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2 Mo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Deputy Administrator 12 Item 27 is marked other other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maxine Ennis Claud Mankins ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 Kintore Court-Parkville, Maryland 21223 Mary Mankins-sister 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel and Cremation-Belair

Date 20c. Location - City or Town, State 20c. Location - Ci 20c. Location - City or Town, State 20a Method of Disposition Department of Important: If it any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Svs 8800 Harford Road-Parkville, MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tarction robable Immediate Cause (Final Myscandin **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (cr as a consequence of) Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit CENTRALITY APPROVED BY MEMORAL Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy Rhenmai certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical examiner?

1 Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division or Attending 1 Natural 5 Pending investigation 1 □Yes 2 No 8/15/09 IIGOA M death. FELL DOWN STAIRS 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide THOME 16 KINTORE COURT, PARKVILLE MD Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Terrarel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sanar tan Hospital Bultimore Ker Good 6. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

SEP 0 9 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 6:15 A. M September 6, Robert A. Manager /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

(Month, Day)

Jan. 12, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Year 925 Mary Tand **Funeral** Days Hours Min. 1**X** M 2 □ F 84 216-14-7841 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, its its deal Event not near be notified. 1 ☐ Yes 2√2 No Director Bel Air Harford Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21014 United States 603 Thames Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? // 1 11. Marital Status 4/1943 1 Never Married 2 Married 1**X**Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 SpecifyWhite 1 □Yes 2√2√No 11/1943 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Graphics Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If item 27 is marked o Estella Brown William Manager 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 819 Cider Mill Lane Bel Air, Maryland 21014 Thomas Manager Sept. Date 9 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Parkville, Maryland 5 Nother (Specify) Entombment Moreland Mem. Park 4 Donation 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir 21. Signature of Funeral Service Licensee 3 Newport Drive Forest Hill, Maryland 21050 is that c° . It he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final cyob OI **Physician** Stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebrovascular disease Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, ~ Hyputepidemia physician and the burial-tran Due to (or as a consequence of): Physician/Medical attending philosophers at the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) cate has been signed by the page 2 should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate | 1 □Yes 2 No 1 ☐ Yes 2 1 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 □Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signatore and title of certifier 29c. License number 00057619 September 6, 2009 32. Registrar's Signature parks

B. Sparks 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joshua Rubente

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

SEH U 9 2009

MSCOSHOOG

6:15AM

September 6,2009

laniger.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 2:51 PM Charles Edward McElwee, Sr. SEPTEMBER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE AGNES 8. Date of Birth (Month, Day, Year)
Oct. 27,1931 If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number Days Hours Months 1 ☑ M 2 ☐ F 218-26-8359 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location MD Baltimore Catonsville 1 ☐ Yes 2 X No. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 1418 Lincoln Woods Drive 21228 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ⊠Yes 2 □ No Black, White, etc 1 ★Yes 2 No
If Yes, Give
Year or Dates: Navy 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 👿 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Little People's Elementary/Secondary (0-12) College (1-4or 5+) 5+ Executive Director Research Fund 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Crickard Harry McElwee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2202 Tall Pines Court; Catonsville, MD 21228 Mark McElwee Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory Glen Burnie, MD 9-5-2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling As ton Schwa Mitz e Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signa of Juneral Se ce Lice Approximate Interval Between Onset and Death 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) HTPOXIA HOURS Due to (or as a consequence of): PNEUMONIA DATS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cancer 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 1 Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Examiner that the death certificate be executed physician and s the burial-trans The law or Attending To the Hospitai To the Funeral

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Vital Records,

of

Division

MCELWEE

Physician

/Medical

Examiner

Physician/Medical

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Certification: To

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/Medical

Examiner

Director

Funeral

<u>ک</u>

Completed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ehromany injury or other traumatic avent

Baltimore, Maryland 21215-0036

within 24

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAPRILLA 31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier

N ROSAVES

main Camelo N. Persales, MD

900 S CATON AVE, BAUTIMORRE ●32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0066007

29d. Date signed (Month, Day, Year)

21229

SEPTEMBER 1, 2009

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Darrell Norwood September 8 Martin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll 317 Main Street New Windsor If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1**X** M 2□ F Director 217-48-6704 62 Nov. 4. 1946 Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show Director New Windsor MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21776 U.S.A. 317 Main St. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Wedgel Engine 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 XNo Specify: Specify: White ģ 3 Widowed 4 Divorced 1966-74 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 county gov. heavy equipment operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Rippeon ပ Eltee Norwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 737 Windsor Dr., Westminster, MD 21158 Martin D. Norwood Jr./son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Linganore Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility E. Broadway, Unior 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 ☐No P.O.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Cremation 3	Removal from State	cemetery, crematory	or other place)	1				
5 ☐ Other (Specify		Linganore C	Cemetery	9/11/2	2009	Unionvi	lle MD	
neral Service Licen	D. V.	22. Nam	e and Address of Fa	^{cility} Har	tzler E	Tuneral H	Iome	
1 to A	normun	6 E.	Broadway.	Union	Bridge	e. MD 217	⁷ 91	
	olications that caused the	e death. Do not enter the					Approxii Interval	mate Between and Death
nditions,	Due to (or as a d	consequence of):					104	w
mediate lying injury	Due to (or as a c	consequence oi).						
ast	Due to (or as a	consequence of):						
	d							
pregnant months?]No	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐ Fetal death 3 ☐ Ector	pic pregnancy r (specify)			23d. Date of Month	,	Year
icant conditions of	ontributing to death but	not resulting in the underlyi	ng cause given in Pa	rt I.		bacco use contrib es 2 □ No 3		of death? Unknow
	31				24a. Was a autops perform	med2 dea	ere autopsy finding or to completion ath?	ngs availabl of cause of
ed to medical			26. PI	ace of Death (Check only or	fe)		
No.	Hospital: 1 ☐ Inpatient	2 ER/Outpatient 3	DOA Other: 4	Nursing Home		ence 6 ☐ Other		
5 ☐ Pending investigation		/ear) 28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2		d. Describe h	ow injury occurred		
6 Could not be determined	28e. Place of Injury building, etc.	- At home, farm, street, fac (Specify)	ctory, office	28	If. Location (S City or Tow	treet and Number n, State)	or Rural Route I	Vumber,
Certifying Phy Medical Exam	ysician: To the best of niner: On the basis of e and manner state	my knowledge, death occu xamination and/or investiga d.	rred at the time, date ation, in my opinion,	e and place, ar death occurred	nd due to the o	cause(s) and man	ner as stated. d due to the cau	se(s)
tle of certifier	M. Let	PAL	29c. License number 2 (23		29d. Date signed (Month, Dey, Yea	2

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1X Yes 2 □ No

Maryland

2009

Black, White, etc.

8:50 A M

within 24 hours a

s after dea.. ral Director: After

Division of Vital Records,

State Registrar

5

Completed

Be

Certification: To

Medical

25. Was case referred to medical

29b. Signature and the of certifier

John M. Lehigh,

31. Date filed (Month, Day, Year)

2 No

1 ☐ Yes

27. Marrier of Death

2 Accident

4 Homicide

3 Suicide

29a. Certifier

32. Registrar's Signature

ORIGINAL

104 N. Main St., Union Bridge, MD 21791

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. C. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September Day, 2009 11:45am **Physician** Frank C. Naylor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Carroll Hospice Dove House Westminster 9. Birthplace (State or Foreign Country)
MD If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, May 17 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1925 1 XM 2 ☐ F 84 Director 217-12-8553 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 □ Yes 2 ¬No **Funeral Director** MD Carrol1 Sykesville the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, If e Madical Examinational Denamone. USA 21784 6816 Littlewood Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 1 ¬Yes 2 □ No Black, White, etc 1 √Yes 2 ☐ If Yas, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. Specify: White Be Completed by 3 Widowed 4 ☐ Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Payroll/Accounting Time Keeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katie M. Stallings Francis C. Naylor 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6816 Littlewood Court Sykesville, MD 21784 Mr. Steven C. Naylor (Son) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 9/11/2009 Lake View Mem. Park Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, P.A. MOOTEN PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) maric **Physician** /Medical Due to (or as a consequence of): Examiner on les hu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 □ No 2 ☐ Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier within 24 ho

To the Fune

completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Name and address of person who completed cause of death (Item 23a) (Type, Pript

Registrar's Sign

5

Year)

SEP 0 9 2009

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #11, per Fh 9896 10/14/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 5, 2009 9:45P KATHRYN NOLAN 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Stella Maris Timonium If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 26, 1930 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 Pennsylvania 79 172-30-0954 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 🛪 🗖 No Maryland Baltimore Timonium 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2300 Dulaney Valley Road 21093 USA . Was Decedent Ever in U.S. Armed Forces? 1 Yes XX No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 N Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Encyclopedia Sales Representative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Shadduck Zura Wheeler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2525 Pot Spring Road #L711 Timonium Maryland 21093 Leo Charles Nolan Jr Husband Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 💢 🔭 remation 3 ☐ Removal from State Green Mount Crematory Sept 11,2009 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name end Address of Facilitohn O Mitchell IV Funeral Service of conature of Funeral 5 / ice Licensee Dulaney Valley 200 East Padonia Road Timonium Maryland 21093 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Diay to for es a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

burial-transit death certificate be exec sate has been signed by the attending physician page 2 should be detached for use as the buria P.O. Box 68760

this certificate within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Funeral

Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Nedical Examinating the notified at

Physician /Medical

Examiner

Examiner

Physician/Medical

Completed

Be

၉

Certification:

Medical

3 ☐ Suicide 4 Homicide

Baltimore, Maryland 21215-0036

Division of Vital Records, ELOISE0 Hospital

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2☐ Medical Examiner: On the basis of exam X NURSE PRACTMENTED WER 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature apd

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

s of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 JACKIE JONES, 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

6 ☐ Could not be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 30A 1. Decedent's Name (First, Middle, Last) Marie Owens September 2 2009 Pauline 4c. County of Death 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) AM If Under 1 Year If Under 24 Hrs. North, Days Hours Min. Jan. 3, 191 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Social Security Number 1 M 200 Yrs. Pennsylvania 1919 220-09-0167 90 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Maryland Harford Agingdon 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21009 803 Baker Ave. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 € Divorced Year or Dates 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (Unknown) Helen Ignatius Umerley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6868 Century Farms Rd. Felton, Pennsylvania 17322 Francis L. Owens / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of Evander rimator and the place | Sept. Bel Air 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Home & Cremation Service—Bel Air 3 Newport Drive Forest Hill, Maryland 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of ly one cause on each line. Immediate Cause (Final END Stone Chroni resulting in death) Due to (or as a * insequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Thypothymidism, commy atternitions 21/2 No Yes

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Directo

Funeral

δ

Completed

Be

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore,

The law requires that the death certificate be executed sician and burial-trans attending physic been signed by the should be detached has

Division or Vital Records, P.O.

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate by

in by the funeral

completely filled

Physician/Medical

Completed

Be

2

Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 9 Unknown

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending

2 Accident

(Check only one)

3□ Suicide

28a. Date of Injury (Month, Day Year) investigation

28b. Time of Injury

2 ER/Outpatient 3 DOA

Other: 4 Mursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ↑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

1 Inpatient

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

nmo

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

e pail red Bek Ain mn 27014

State Registrar 31. Date filed (Month, Day, Year) SEP 0 9 2009

m 32. Registrar's Signatu 09-06881 Jayden Oakes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day September 3, 2009 0146 hrs **Medical Examiner** 0akes Javden_ 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore N/AUniversity Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 7. Age (In yrs. last birthday) Foreign Country) Maryland 5. Social Security Number 6. Sex **Funeral** Davs Hours Months Director 08/28/2009 XM 2 unk Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 X Yes 2 No 23a or 28a-f show notified at once, Baltimore Maryland N/A Director 10g. Citizen of What Country? 10e. Street and Number 2411 Saint Stephens Court Apt. 21216 United States 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 XNever Married 2 Married 2X No Yes Yes 2 X No specify: White Specify: If Yes, Give Year tem 27 is marked other than "natural", traumatic event, the Medical Examiner 3 Widowed Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hot Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natinjury or other traumatic event, the Medical Examigury or other traumatic events. Elementary/Secondary (0-12) College (1-4 or 5+ 0 Never Worked 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LeeAnn Evert Be Michael A. Oakes

19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saint Stephens Court Apt.2A LeeAnn Evert/ Mother Baltimore, MD 21216 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, September 4. 20a. Method of Disposition crematory or other place) Removal from State Burial 2 X Cremation 3 Baltimore, Maryland Metro Crematory. Inc Donation 5 Other Specify 22. Name and Address of FacilityCremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Between Onset and Physician failure. List only one cause on each line Death Medical Multiple congenital anomalies Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED <u> 23a,27.perME, g897 11/10/09 TT</u> attending physician or use as the burial 23d. Date of delivery Box 68760. 23c. If yes, outcome of pregnancy IF FEMALE: Year Month Dav 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months' Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 V No 3 Probably 4 Unknown ģ Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy icate has b performed' death? No ✔ Yes 2 1 V Yes No certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director; 25. Was case referred to medical Division of Vital Be Other₄ Hospital: Residence 6 Other Nursing Home 5 Inpatient 2 V ER/Outpatient 3 1 V Yes Certification: To 28d. Describe how injury occurred 28c. injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death 1 X Natural 1 Yes 2 No Pending Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 3, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a)

Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

111 Penn Street, Baltimore, MD 21201

State Registra

09-06846 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Teletha Ann Price State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2 Date of Death Time of Death Month **Medical Examiner** Price 1739 hrs Teletha Ann September 1, 2009 4a. Facility Name (if not institution, give street and number) 4b City Town or Location of Death c. County of Death Bon Secours Hospital Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funeral Foreign Months Davs Min. Hours Director 09 14 57 Country) MD 52 215-78-4438 1 M 2 XF Yrs Usual Residence of Decedent any 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits Baltimore 1 X Yes 2 No 28a-f show NA tant: If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the <u>Medical Examiner must be notified at once.</u> MD and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21216 U.S.A. 1145 North Bentalou Street Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 White, etc. Yes 3 Widowed Divorced If Yes. Give Year Yes 2X No specify: Black 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages I and 2 should be uneversely one of Health and Mental Hygiene. MD 21215-0036 Hospital Housekeeping 12th grade 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) Mary Sue Smith Johnny Lee Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1145 North Bentalou Street, Baltimore, Patricia Price-Sister Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Baltimore, Date 20c. Location - City or Town, State crematory or other place) 1X Burial 2 Cremation 3 Removal from State King Memorial Park Woodlawn, Donation 5 Other Specify Signature of Funeral Service Licensee March Afrend Fweittyst 4300 Wabash Ave, Baltimore, Md art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval ilure. List only one cause on each line Between Onset and 'Medical a Hypertensive Atherosclerotic Cardiovascular Disease mediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last red by the attending physician and detached for use as the bunal - transi hysician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 죠 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? this certificate has been signed if director, page 2 should be deta ठ 1 Yes 2 No 3 Probably 4 V Unknown Diabetes Mellitus eted page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? Com ✓ Yes 2 No 1 🗸 Yes 2 No director, Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Nursing Home 5 Residence 6 Other DOA 1 🗸 Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural Director: Pending 1 Yes 2 No within 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E September 2, 2009

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

rar's Signature

Russell Alexander MD

31. Date filed (Month,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician SEPTEMBER PM4:20 FRANCES MARGARET /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK HOSPITAL FREDERICK MEMORIAL FREDERICK Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Min. Months Days Hours 1 □ M 2X F Washington 49 July 27, 1960 021-52-1834 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, the New Ical Evan. And to other traumatic event, the New Ical Evan. 1 ☐ Yes 2 X No Director Frederick New Market MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 10697 Finn Drive 21774 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 1 ☐ Never Married 2 X Married Puerto 1X Yes 2 □ No Specify: ð White 3 Widowed 4 Divorced Rican Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15, Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Compliance officer Federal government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jesse J. Acosta Angela Flores ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donald Joseph Pell/husband <u> 10697 Finn Dr., New Market, MD 21774</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/4/2009 Libertytown, MD St. Peters Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licens 11802 Liberty Rd., Libertytown, MD 21762 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Breas **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Ye ar in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ 16 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 21702 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Tohnson shal 31. Date filed (Month, Day, Year) 32. Registrar's Signature State rank Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Day 5, 1. Decedent's Name (First, Middle, Last) **Physician** 2009 5:20am м September Walter Pohlman, Jr. Harry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Carroll Carroll Hospice Dove House Westminster 8. Date of Birth (Month, Day, Ye July 18, Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 19<u>30</u> **Funeral** Months Days Hours Min 1 👿 M 2 🗆 F Yrs. 79 218-26-8255 **Director** Usual Residence of Decedent 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director Carrol1 Westminster MD 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number 21157 300 Shadybark Court #5 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Myes 2 □ No If Yes, Give Year or Dates: Korea 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mes College (1-4or 5+) Elementary/Secondary (0-12) Transportation 8 Cab Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Bowman Harry Walter Pohlman, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Pamela Hobson (Step-daughter) PO Box 733, Chincoteague, VA 23336 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Providence Cemetery 9/7/2009 21. Signature of Funeral Service Licenses HAIGHT TUNERAL HOME & CHAPEL, P.A. X. Huight 400764 PO Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): DA ZOCAF **Examiner** espente Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of Examiner certificate be execute and burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the as asn If yes, outcome of pregnancy
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rriet Phelps		State of Maryland / Department of Health a	and Mental Hy		20	09 2866
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COF law i has t	Completed			perform 1 ✓ Yes 2		ath? ✔ Yes 2 No
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n of Vital Iding Physician: h. After this certif e funeral director,	a	examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 D	OA Other Nu			Other:
of V Phys ter thi	l ⊢	27 Manner of Death 28a Date of Injury 28b. Time of Injury 2	8c. Injury at Work?	28d. Describe h	ow injury occurred	
on Conding th.	<u>.</u> [1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			
isio	is	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory	, office building, etc.	28f. Location (S or Town, St	treet and Number ate)	or Rural Route Number, City
Es after led in grant led in gr	🗒	3 Suicide 6 Could not be determined (Specify)				
fospit 4 hour	၂ ဋ	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the	time, date and place,	and due to the cause	s(s) and manner a	s stated.
Division of Nothing Physical Republic States of Particular Physical or Attending Physicial 24 hours after death. To the Funeral Directors. After it completely filled in by the funeral	Medical Certification:	San Certifying Physician: To the best of my knowledge, death occurred at the one) 2	opinion, death occurre	ed at the time, date a	and place, and do	
1	Ne Ne	29b. Signature and title of certifier	c. License number			d (Month, Day, Year)
		his his no	O.C.M.E.		September 2	1, ZUU8
		30. Name and address of person who completed cause of death (Item 23a)				
		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Balti	more, MD 21201			
	Stat	te 31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regi	stra	SEP 09 2009 Resure & parked				
DHMH 17 Rev 1	/2001	ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per INF G899 1/21/2010 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear 6,2009 11:05FM SEPTEMBER aro 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Joseph Medical Center Tawson If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 252 Sezziy 5603 Min. Hours 252 82 5630 1 M M 2 □ F Months Days 20 June 9, 1920 maine Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 👿 No Saltimore DWSON 10g. Citizen of What Country? 10e. Street and Number 11tec 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Floalyst 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Garland ila rintor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Purintor 501 lowson modias 20b. Place of Disposition (Name of cemetery, crematory or other place)
Euros Funeral Chapel Date 20a. Method of Disposition 12009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8 Forest Itill 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ears Fineral Chapel & Cremation Services - Monkton 16924 York Road Monkton mb 29111 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MASSIVE BLEED GASTROINTESTINAL disease or condition resulting in death) Due to (or as a consequence of): URINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DEMENTIA Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy performed 1 ☐ Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

/Medical Examiner be executed 68760. P.O. Division of Vital Records,

burialphysician at the burial To the Hospital or Attending Physician: The law requires that the death certificate as attending p for use as the þ signed t peen cate has t certificate director this After thi funeral within 24 hours after co...

To the Funeral Director: Aft

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show

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permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. important: if Item 27 is marked other than "na any Injury or other traumatic event, IT a Methe once.

Physician

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Completed

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Certification: To

Medical

4 Homicide

(Check only one)

29a. Certifie

traumatic event, the Medical Examiner must be notified at

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

D41410

2000

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

MEHTO M. I.

32. Registrar's Signatur OSLER DRIVE TOWSON, MD 7601 31. Date filed (Month, Day, Year)

SEPTEMBER

OLENDA PINCHBACK

State Registrar

MARIAM BARTR, 31. Date filed (Month, Day, Year)

itle of certifier

SEP 0 9 2009

29b. Signature and

2300 DULANEY VALLEY RD. 32. Registrar's Signature

ss of person who completed cause of death (Item 23a) (Type, Print)

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TIMONIUM, MD 21093

			For State Registrar	State of Ma	rylan		tificate of		i wentai Hy	giene Reg. No.	0119	28664
			Decedent's Name (First, Middle, Last	st)					2. Date of De			3. Time of Death
	Physici	an	Edward, E						Month	Day 6	Year 2009	1418 M
***	/Medic		4a. Facility Name (If not institution, giv				4b. City, Town, o	r Location of Do			ounty of Death	
	Examin	er	Northwest		2-7				atri		3 ath	
							Randalls If Under 1 Year	If Under 24 Hi	rs 0 Data of Di	`		place (State or Foreign
	Funeral		· ·	X M OF F		ast birthday). Yrs.	Months Days	Hours Mi		ay, Year)	Cou	ntrv)
	Director		219-34-0655 Usual Residence of Decedent		71	113.			09-24-	-1937	Mary	land
	and w		10a. State 10b. County		10c. City	, Town or Loc	eation				1.	10d. Inside City Limits
	Sho	ō	36 3 1 - 4 4									1 ∐Yes 2 No
	28a-1	Director	Maryland Baltimo	re	Rei	sterst	_			40 Oiline	n of What Cou	-t0
	vith vith	Ë	10e. Street and Number				10f. Zip Code			rug. Citizei	1 of What Cou	nury?
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36	or i	by F	1 Never Married 2 Married	If Yes, Give	0	1	□Yes 2 No	Specify:		St	pecify: Bla	ick
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r ₂	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show ha Madical Examinat mast be redified at	Completed	15. Decedent's Ed (Specify only highest gra			(Give)	lent's Usual Occup kind of work done	during most of w	orking	16b. Kind	of Business/In	idustry
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ū	be fill half half half half half half half ha	Be	17. Father's Name (First, Middle, Last)						ame (First, Middle	e, Maiden Su	rname)	
yla	Mer Mer arke	은	Alexander Holid	2				Edna P	ayne			
Maryland 21215-0036	2 sh l and ls m raum	0 8	19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	g Address (Street	and Number or	Rural Route Numb	ber, City or T	own, State, Zij	p Code)
2	and lealth m 27 her t		Shirley B. Payne	(Wife)			amershire					
ore	les 1 of F if ite or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. P	lace of Disposemetery, crem	sition (Name of natory or other plac	ce) :	Date	20c. Loca	tion - City or To	own, State
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	П	4 □ Donation 5 □ Other (Specific		St.	Luke (Cemetery	9-1	2-2009	Reiste	erstown	, Maryland
alt	port port y inj	1	21. Signatu's of Fyneral Syrvice Lice	eue		22	. Name and Addre	ess of Facility	11824	Reist	terstow	n Road
m	8 9 7 8 8	1	J	.Wayne Oste	erli	ng EI	LINE FUNE	ERAL HOM	E Reist	erstov	vn, MD	21136
			23a. Part I. Enter the Viseasi, or com shock, or heart fallure. List only	plications that caused t	the death	n. Do not ente	er the mode of dyir	ng, such as card	iac or respiratory	arrest,		Approximate Interval Between
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	/Medical		disease or condition resulting in death)	a. Due to (or as a								
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		ē	Sequentially list conditions, if any, leading to immediate cause. End of Jury g	Due to (or as a	cons qu	ience of):	1					
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Ć,	exec in an ial-tr	Exa	resulting in death) Last	Due to (or as a	consequ	ence of):		-				
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Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death. To the Funeral Director: After this certificate has been signed by the at completely filled in by the funeral director, page 2 should be detached for	Medical Certification: To Be Completed	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past II. Other significant investigation investigation investigation investigation investigation investigation of the past II. Other investigation in the past II. Other significant conditions of the past II. Other significant conditio	Hospital: 28a. Date of Injur (Month, Day, 1) 28e. Place of Injur building, etc. 1 28e. Place of Injur building, etc. 1 28e. Place of Injur building, etc.	t 2 X Year) The transfer of d	ER/Outpatien 28b. Time of Injury me, farm, stre Wledge, death tion and/or inv Physicia 23a) (Type, F	derlying cause give to a DOA Other (specify)	26. Place of D er: 4 □ Nursing y at k? Yes 2 □ No me, date and pla opinion, death oc se number	24a. Was auto perfit of the pe	tobacco use Yes 2 s an spsy s an s an	Month contribute to to the contribute to to the contribute to the	the cause of death? the cause of death? bably 4 Unknown oppy findings available ompletion of cause of 2 No ify) al Route Number, stated. to the cause(s) Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** September 3:20 A M Margaret Friederike Pilger /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 1805 Desoto Road Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Dec 26, 19 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 □ M 2 🗓 F Germany 1947 241-13-6655 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Exymiter mast be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 21 No Director Anne Arundel Brooklyn Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21225 1000 Jack Place Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify Specify: White 2 3 Widowed 4 □ Divorced Completed 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Warehouse Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unk Friederike Zachau 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1805 Desoto Road Baltimore, Maryland 21230 Ralf L. Zachau, Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/04/09 Baltimore, Maryland Metro Crematory Inc. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee Thomas Gregor Cremation Society Of Maryland, Inc. Thomas 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Nonsmall cell Cancer 16 months Metastatic Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consequence off Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnate 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) been signed by the should be detached in 9 Unknown 23e. Did tobagco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 🔲 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has l autopsy performe certificate ha 2 Win 1 ☐ Yes 2 ☐ No 7. After this cerum. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \cancel{K}$ Other (Specify) 1 ☐ Yes 2 ☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated.

State Registrar 29b. Signature and little of certifier

900 CATON AVE BALTIMORE MD 21229

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D16354

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 5, EDWARD BERNARD QUINN, SR. SEPT. 2009 3:45 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE PRESBYTERIAN HOME OF MARYLAND TOWSON If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year **Funeral** Months Days Hours 212-18-9593 88 APRIL 11,1921 Director Usual Residence of Decedent with the Maryiand 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo BALTIMORE ROSEDALE 10g. Citizen of What Country? 10e. Street and Number USA 25 BROADBRIDGE RD 21237 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must ance. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No WHITE If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) LOGISTICS MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELIZABETH C. KILCHENSTEIN ROBERT J. QUINN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 25 BROADBRIDGE RD BALTIMORE, MD 21237 EDWARD B. QUINN, JR.-SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 9/9/09 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral Service Licensee BALTIMORE, MD 21206 6415 BELAIR RD , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final **Physician** one week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4x Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) s after death. 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 🗲 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Sent miler 8, 2009 037016 6701 N. Ch- by St, Sa. te 4104 B; Homon, my 21204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenneth M. Green ms 31. Date filed (Month, Day, Year) 32 Registrar's Signature

Registrar

SEP 09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 15 COM James /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOWARD CO 10538 JASON LANE COLUMBIA Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F Months Days Hours Min. Director 63 DEC. 12 1945 MARYLAND 218-44-1152 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or Items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 ☐XNo Directo MARYLAND COLUMBIA HOWARD CO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 U.S.A. Funeral 10538 JASON LANE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after ment of Heath and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Ite ury or other traumatic event, I'm Mades I carry in ury or other traumatic event, I'm Mades I carry in ury or other traumatic event, I'm Mades I carry in 1 ☐ Yes 212 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Specify: BLACK Specify: ģ 3 → Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CITY OF BALTIMORE llth grade HIGHWAY SUPERVISOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ unknown unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty A. Ward/Caretaker 10538 Jason Lane, Columbia, Maryland 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 109-08-09 DUNDALK, MARYLAND MT CARMEL CEMETERY 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 21. Signature of Funeral Seprice Vicensee 1206 W NORTH AVENUE art 1. Enter the diseas shock, or heart failure Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consumer of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is it lated as each Physician/Medical Examiner Due to (ut as a consequence up. The law requires that the death certificate be executed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) i signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has trail director, page 2 s autopsy performed; 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗖 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1∐ Yes 2√2No 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Division of Vital Records, P.O. Box 68760, To the Hospital within 24 hours a

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

(Check only one)

WINS BYE 31. Date filed (Month, Day, Year) Registrar's Signature SEP 0 9 2009

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death .o. Location of Death 4b. City, Town, Facility Name (If not institution give street and numb Examiner altimore Birthplace (State or Foreign Country) f Under 24 Hrs. If Unde **Funeral** Min Months Days NY 076-74-1912 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Expendit or must be redified at Yes 2 □ No Director New Egypt Ocean 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 08533 821 Route 539 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1 ∐Yes Ž∭ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) East Coast Elementary/Secondary (0-12) College (1-4or 5+) Super Charging Shop Manager 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Inez Woodard John Romano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is IT any Injury or other traum once. 821 Route 539, New Egypt, NJ 08533 Kristine Romano-Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cream Ridge, NJ 9/14/09 Cream Ridge 22. Name and Address of Facility
March F/H West 21. Signature of Fotheral Service Lice 4300 Wabash Ave, Baltimore, Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed the burial-tra Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the i detached 9 | Unknown þ s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed 2**X**No 1 XYes 2 🗆 No 1 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA After this funeral dir Medical Certification: To 28b. Time of Injury Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation r death. s after death.

I Director: A in by the fu Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours after

To the Funeral Directory filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) d manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ;

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 2:45 A M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** dw. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral Country) 62. 1 M 2 **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Medical Examiner must be notified at Director Yes 2 No TIMONE 10g. Citizen of What Country? 10e. Street and Number Apot 10f. Zip Code Funeral 212 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene. neloria wil Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Shearin Hula permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) amenen ammons שע Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State cemetery, crematory or other 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ture of Funeral Service Licenson 22. Name and Address of Facility a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (FMal Physician/ disease or condition resulting in death) CC Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consection of and as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No

9 Unknown Pregnant at time of death Day Month Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat d title of certifier 29d. Date signed (Month, Day, Year) 2009 address of person who completed cause of death (Item 23a) (Type, Print) AMON

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day Year)

-VES

82. Registrar's Signature

			1- State of Maryland / Department	artment of Health and M rtificate of Death		ene No.C 0 U S	23670			
	Dhyaiai		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death			
	Physicia /Medic		RANDY L. KEINECK			06 09	1315 pm			
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death				
od.	Funeral	-	The Tate House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Linthicum If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Anne Arunde 1 9. Birthplace (State or Foreign				
	Director		212-13-0645 1 M 2 F 36 Yrs.	Months Days Hours Min.	(Month, Day, Ye		untry) [aryland			
	and		Usual Residence of Decedent 10a. State	cation			10d. Inside City Limits			
	Maryli f sho	tor					1X Yes 2 □ No			
	be filed within 72 hours after death with the Maryland ital Hygiene. So other than "natural", or items 23a or 28a-f show event, the Medical Experiment must be relified at	Director	Florida Hillsborough Tampa 10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	untry?			
	23a c		11233 Cypress Reserve Drive	33626	υ	Inited Sta	tes			
	er dea	Funeral		Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White				
0036	irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ሺ No If Yes, Give 3 ☐ Widowed 4 17 Divorced Year or Dates:	1 □Yes 2 ሺ No <i>Specify</i> :		Specify:	hite			
<u>ب</u> ک	2 hou natura		15, Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during most of worki	16	b. Kind of Business/				
Ž	ithin 7 ne.	Completed	(Specify only highest grade completed) (Give life. I	Nina of work done during most of worki DO NOT use retired)	ng					
7	led wi Hygier her th			int Operator	O (First, Middle, Mai	idan Surnama)	ing			
and	d be fi) Be	17. Father's Name (First, Middle, Last) Michael R. Reinecke	Elain		Reid				
3	s 1 and 2 should be f f Health and Mental item 27 is marked of other traumatic eve	2		ng Address (Street and Number or Rura			Zip Code)			
Ĭ,	and 2 salth a 27 is er tra		Michael Paul Reinecke/brother 1605	Picadilly Court	Crofton,	Maryland	21114			
ore	es 1 g of He fitem		20a. Method of Disposition 1 ☐ Burial 2 ፟ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cremation 3 ☐ Removal from State			c. Location - City or				
	Pag tment tant: I		4 □ Donation 5 □ Other (Specify) W Arunde 1	Crematory 9/9/		denton, M				
Dalt	permit. Pages 1 and 2 Department of Health of Important: If item 27 is any injury or other tra once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility pnaldson Funeral H 11 Annapolis Road	ome & Cre Odenton	matory, P Marvlan	.A. d 21113			
П			23a. Part 1 Inter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.				Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	ver			Onset and Death			
1	/Medical Examiner		Due to (or as a consequence of):) -			
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of);							
	outed ansit	Examine	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events							
Ď,	e exectian ar ian ar irial-tr	Ex	resulting in death) Last Due to (or as a consequence of):							
0/0/0	cate be executed physician and the burial-transit	dical	d				44.4			
OX O	ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			201 0-1				
0	leath atten for u	Physician/Me	in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of del Month	Day Year			
Ċ	t the c by the achec	hysi	9 ☐ Unknown							
'n.	es tha igned se det	by P	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?			
ecords	requir een s nould	ted			1 ☐ Yes	2 No 3 Pr	obably 4 Unknown			
Se C	e law has b e 2 st	Completed			24a. Was an autopsy	prior to	topsy findings available completion of cause of			
וומו	n: The ficate r, pag				performe 1 □ Yes 2 □		2 🗆 No			
5	/sicial	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	Other:	n <i>(Check only one)</i> me 5 ☐ Residend	on a Mothar Con	TE HOSPICE			
5	g Phy er this	Certification: To	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how		HUNSE			
SION OF	andin ath. or: Aft ne fun	atio	2 Accident investigation	M 1 Yes 2 No						
<u>"</u>	or Atterdeterde	ij	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ıral Route Number,			
ב	pital c		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	b coolinged at the time, date and along	and due to the same	(-)d	a state of			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat a manner on the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, date	se(s) and manner as and place, and due	to the cause(s)			
	vith vith com	Σ	29b. Signature and title of certifier	29c. License number		. Date signed (Month				
			Mila Josentam	021438	(Jeg Herri	ur 01,2001			
	101		30. Name and address of person who completed cause of death (Item 23a) (Type, MICHAEL J. La FINTH MY YYY DE	FENSE HAH RIDG	GRn 1	ANNAPOL	s uprival			
	Sta Registra	_	31. Date filed (Month, Day, Year) SEP 0 9 2009 32/Registrar's Signature	akel						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 7. **Physician** Audrey Roupe 2009 Jean September 21:25 P^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Johns Hopkins Bayview Center Baltimore 8. Date of Birth (Month, Day, February 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 17,1930 1 □ M 2 🗓 F Months Days Hours 218-26-4491 79 **Director** Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral", or items 23a or 28a-f shov Director 1 Yes 2 No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6808 Broening Road 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 1 ∏Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛣 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home 12 years permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If item 27 is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Homer M. Varner Minnie E. Stem ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6808 Broening Road, Dundalk, Maryland 21222 Charles Roupe Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 11, 2009 Dundalk, Maryland 22. Name and Address of Facility. Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease of complications that caused the deat of onot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): P.O. Box 68760, for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 1 □ Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate l 2 **N**o 1 □ Yes the funeral director, Medical Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2. No 1 Inpatient ≥ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ⊟ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral L 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D0069314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sute 204, Parkertle Walthem Woods 31. Date filed (Month, Day, Year) 2. Registrar's Signature State SEP 09 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** Mary Theresa Francisann Rapa aptenbary 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner None Baltimore ttimore HOSPITAL 8. Date of Birth (Month Day, Year) May 17, 1931 9. Birthplace (State or Foreign Funeral Social Security Number 1 □ M 2(X)F Months Days Hours Min. New Jersey 138-24-8795 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Madical Examiner must be notified at 1 □Yes 2 XXVo Funeral Director Baltimore Marvland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21208 USA 7211 Park Heights Avenue #201 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes No If Yes, Give Year or Dates: XX Never Married 2 Married 1 □Yes XX No White Baltimore, Maryland 21215-0036 Specify Completed by 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 to Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainer. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Parochial School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Mae Filippo Francis A Rapa ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 North Charles Street Baltimore, Maryland 21212 Sr Bernice Feilinger SSND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Kaurial 2 Cremation 3 Removal from State Villa Maria Cemetery 9/9/09 Glen Arm, Maryland 4 ☐ Donation 5 ☐ Other (Specify) gnature of Funeral Service Licenses 22. Name and Address of Fathritchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** omplications

Due to (1 as a consequence of): ssociated w Hypertension disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No ned by the atter detached for u 3 - Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 🗆 No 1 ☐Yes 2 000 : After this certific funeral director, 25. Was case referred to medical examinar?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 Natural after death.

I Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Thomicide e Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 2 To the I 29b. Signature and title of certifier rson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

Known as

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Physician SEPTEMBER Nettie Stella Recktenwald 26:22AM 03, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Medical Saint Center Towson Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 214-01-8525 95 Sept. 22, 1913 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, "na Modical Examinar must be multified at Baltimore Parkville Director MD 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2500 Linwood Road 21234 U.S. A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White ð 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Welfare Transcriptionist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Truss Helen Lentowski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If Item 27 Is any injury or other trau Sally Borsella/Daughter 4790 Skyview Drive, Glenville, PA 17329 20b. Place of Disposition (Name of cemetary, crematory of other place)
More I and Memorial 09/08/09 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) Park 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death imm ediate Cause (Final dist ase or condition sulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Dissass or injur that initiated events resulting in death) Last physician and the burial-tran Due to (or as a consequence of): 68760 Physician/Medical attending p for use as t Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) o 9 Unknow by ۵, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by HEART 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page certificate 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 3,2009 DØØ17695 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABDALLAH M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Darker

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 2, 2009 **Physician** 9:00 P M **EDNA** REAVES /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, June 27, 9. Birthplace (State or Foreign Country) North Carolina Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1924 Months 1 □ M 2 🔀 F 239-24-3572 85 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford Forest Hill Maryland 10g. Citizen of What Country? 10e. Street and Number items 23a or 1405 Persimmon Place 21050 United States by Funeral permit. Pages 1 and 2 should be filed within 72 hours after death D-partment of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or items 23 important: If Item 27 is marked other than "natural", or items 23 in jujury or other traumatic event, Ite Medical Examination onto. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify.White 1 ☐ Yes 2XXXIo 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shelley Mitchell Senia Hall ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Maxwell / Daughter 1405 Persimmon Place Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Septate 5, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial 2009 Timonium, Maryland 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir 3 Newport Drive Forest Hill Maryland 21050 of Funeral Service Licenses 23a. Part 1. Enter the disease, or constructions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLE **Physician** MOUNSOUND disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician. The law requires that the death certificate be executed use as the burial-transi Dinhere resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mo ths? 3 Ectopic pregnancy in the past 12 mo 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation neral Director: A 1 ☐ Yes 2 🗌 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a, Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and the of cortified

ROBERT DUNCAN

31. Date (iled (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 W.

32. Redistrar's Signature

BEL AIR, MD.

MACPHAIL ROAD

29d. Date signed (Month, Day, Year)

21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death nay Month Physician/ Michael M. Regula M 009 Sentembe Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs.

14 and the Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 89 212-12-6277 Director 919 Maryland entember Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Nottingham Baltimore Md. 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? must be n ō Funeral 21236 USA 2 Bellington Ct. itеms 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1941 − 1945 1 ☐ Yes 2√ No Specify: White "natural" Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) the Produce Wholesaler 8th permit. Page 1 and 2 should be filed in Department of Health and Mental Hy, Important: If item 27 is marked othnany injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Victoria Doras Paul Regula 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BelAir, Md. 21015 603 W. Ring Factory Rd. Grandson George Schreiner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State <u>Heart of Mary 9-10-2009</u> 4 Donation 5 Other (Specify) Dundalk, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Nottingham, Md. 9705 Belair Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Pnysician/ Medical resulting in death) Due (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Day Pregnant at time of death Yes 2 No ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to be detailed by 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No 1 Yes 2 No certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death. To the Funeral Director: After this or 28a. Date of injury (Month, Day, Year) 27. Manner of De th 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗆 Yes 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) HMMER W

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 2 2009 **Physician** Andrew Alan Rutledge /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Co College Park 9800 Cherry Hill Rd. Lot 718 9. Birthplace (State or Foreign Country)
New Mexico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-12-1947 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1**™** M 2□ F 454-80-1162 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or items 23a or 28a-f show permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Iro Medical Exp. virust must be notified at 1 ☑ Yes 2 ☐ No Director N/A Houston TX10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12423 Old Oaks Drive USA 77024 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No Specify. Specify: White ģ 3 ☐ Widowed 4 💆 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patricia Freeman William Rutledge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12423 Old Oaks Drive Houston, TX 77024 Michael Rutledge- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Bayview Crematory 9-4-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA 1201 Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Atherosc **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for de a consequence of) Examiner and Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No MOTO Home 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Hospital or Attending Physician: The

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Day Year 8:20 PM ah 2009 /Medical Scotember 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NI saltimore Tyear I If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday)
92 Yrs. Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 220-20-3843 1□ M 2×F Months Days Hours Min. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If Item 22a or 28a-f shov any Injury or other traumatic event, It is Medical Exacting to other traumatic event, It is Medical Exacting to motified at 1 ☐ Yes 2 No Director Duyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or,5+) War 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 Fieldview Kd. Com Alfonso mD. 2120 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) Keda 23a. Part / Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedia Cause (Final disease or condition resulting in death)

a. Severe Approximate Interval Between Onset and Death **Physician** duys /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be execute burial-tra Due to (or as a consequence of) physician the burial as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 █ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy for Month Day Pregnant at time of death 5 ☐ Other (specify) Ö been signed by the should be detached 9 Unknown ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by Coronary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? the funeral director Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \Bull Nursing Home Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Graham MD 31. Date filed (Month, Day, Year) Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3. Time of Death Month MARLENE MARY SKELTON Spotember 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) n, or Location of Death 3. Date of Birth (Month, Day, Year) 5 - 8 - 1941 Age (In yrs. last birthday) If Under 1 Year Number Months Days Hours 1 □ M 2 🗗 F 68 217-40-7153 Vrs MARÝLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location MD BALTIMORE ROSEDALE 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 914 ROSEDALE AVENUE 21237 U.S.A Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No 1 ☐Yes 2 No Specify. Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) FRANKLIN SOUARE Elementary/Secondary (0-12) College (1-4or 5+) 12 ACCOUNTING DEPARTMENT HOSPITAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAMES JOHNSON Η. ROSE (MOSCARIELLO) 19a. Informant's Name/Relationship (Type. PrintHUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPH ALLEN SKELTON SR 914 ROSEDALE AVENUE ROSEDALE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State METRO CREMATORY 9-9-09 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME of Funeral Service Licenses 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final erentovasculai disease or condition resulting in death) Due to (or as a consequence of): Fibrillation Se quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last oronary Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year Month 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examinar mast be notified at

death with the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other trainment.

Maryland 21215-0036

Baltimore,

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Examiner

cate has been signed by page 2 should be detach certificate has funeral director, this After death. within 24 hours after death To the Funeral Director: filled in by the

The law requires that the death certificate be executed

<u>О</u>.

Division of Vital Records,

or Attending Physician:

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State Registrar

Physician/Medical 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> Completed 2 PNo 2 No 1 ☐ Yes 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Drive, Baltimore, MB, 21237

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32. Registrar's Signature

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			Decedent's Name (First, Middle, Last)			7.00				2. Date of De	ath			3. Time of Death
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_	Funeral		5. Social Security Number 6. Se		Age (In yrs. la		If Under	r 1 Year	If Under		8. Date of Bir (Month, Da	rth	9.	Birthpla	ice (State or Foreign
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	h wit	al	8005 Riker Road					210	75				USA		
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3	al",	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dat	es:		I LI TES	2 [3410	Opechy				Specify:	whi	te
ה ה	72 ho	tec	15. Decedent's Edu (Specify only highest grad	ication		16a. Dece	dent's Usu	al Occup	oation	st of work	ina	0	Kind of Busin		•
7	within jiene.	ם	Elementary/Secondary (0-12)	College (1-4	or 5+)			se retire	during mos d)	J. 0	9			_	e County
7	d wil	Completed	7			Custo	dian						ard of	Edu	cation
Maryland Z1Z13-0036	should be filed withi and Mental Hygiene. s marked other thar umatic event, 12. 13.	Be (17. Father's Name (First, Middle, Last)								e (First, Middle		en Surname)		
<u></u>	uld b Ment Irked Itic e	힏	Benjamin Frankli	n Sherm	an, Sr	•			Ca	tner	ine Wel	cn ——			
9	ges 1 and 2 should be filed within 72 hours after death with the Maryla it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, In Madical Event and Don 2011 and or other traumatic event, In Madical Event and Don 2011 and or other traumatic event, In Madical Event and or other traumatic event.	Ι' Ι	19a. Informant's Name/Relationship (7				3				ral Route Numb			ite, Zip (Code)
Ξ	and 2 alth 127 i		Edward L. Sherman	/ Broth	er	8005	Brit	t Ct	., E.	lkri	dge, MD	210)75		
ב	item oth		20a. Method of Disposition		C	lace of Dispo	osition (Na	me of other pla	ce)	Sont	Date ember 8		Location - City	y or Tow	n, State
Ĕ	Page lent on ry ol		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify			Linc				_	009	Bre	entwood	1, M	D
pailillore,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau		21. Signature of Funeral Service Licens		1	2	2. Name a	nd Addre	ess of Facil		aldson	Fun	eral Ho	ome,	P.A.
ă	Depa Impo any ii	1 5	J. Ko. SV.la		M01053						Laurel,				
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Pneum			ter the mod	de of dyi	ng, such a	s cardiac	or respiratory a	arrest,		J.	Approximate Interval Between Onset and Death eeks
	Examme	L	Sequentially list conditions.	b											
	p #	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury	Due to (o	r as a consequ	ience of):									
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as, r.	uires that the de signed by the a Id be detached t	Completed by PI	Part II. Other significant conditions of Respiratory Failu	-	th but not resu	ulting in the u	inderlying (cause giv	ven in Part	I.					e cause of death? ably 4\(\frac{1}{2}\)Unknowr
င္ပ	w requir been s should	lete	Deconditioning								24a. Was	s an	24b. Wei	re autop	sy findings available
Ğ L	ne law has ge 2 s	m	Deconditioning		· ·				-		auto		prio dea	r to com	pletion of cause of
<u></u>	n: The										1 □ Yes	2 🔀	No 1 □	Yes :	2 3 No
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5	Phys this aldii	은	1 ☐ Yes 2 ②No 27. Manner of Death	1 ☐ In 28a. Date of	patient 2	ER/Outpatie		UA	47-11	lursing H	ome 5 ☐ Res 28d. Describe			(Specify)
=	ing Phys 1. After this funeral di	<u>0</u>	txXNatural 5 ☐ Pending	(Month	, Day, Year)	Injury	M	28c. Inju Wo	rk?]Yes 2.∐	TNo.	200, Describe	HOW III	jury occurred		
DIVISION OF VITAL ACCORDS,	I or Attendi after death. Director: A	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place o	f Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, st			1165 2	1110	28f. Location City or To			or Rural	Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the bar iner: On the bar and manne	sis of examina	wledge, dea tion and/or i	th occurred	d at the t n, in my	ime, date a opinion, de	and place eath occu	, and due to the	e cause e, date a	e(s) and mann and place, and	er as st due to	ated. the cause(s)
	To the vithing coming the coming	ž	29b. Signature and title of certifier	10.9	h /		29		se number				Date signed (A		
					m.	ク		D53	411				septemb	oer	3, 2009
	V P		30. Name and address of person who	ompleted cause	of death (Item	23a) (Type,	Print)				1000				_

State Registrar 31. Date filed (Month, Day, Year)

Jagdish Chandra Shesadri, MD, 14300 Gallant Fox Ln., #210, Bowie, MD 20715

32, Registrar's Signature

_			1 - State of Maryland / Department of State of Maryland / Department of Certificate		lental Hygie Reg.		28680
	Physici /Medi		Decedent's Name (First, Middle, Last) JOHN WRIGHT SLOAN		2. Date of Death Month September	Day Year 7 2009	3. Time of Death 4:55 AM
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland CD Department of Health and Mental Hygiene. Unportant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experience unantipe restricted any once.	Completed by Funeral Director	4a. Facility Name (If not institution, give street and number) 4100 North Charles Street, #414 Ba	4c. County of Death			
, Maryland 21215-0036			215-18-8011 84 Yrs.	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye Oct 3, 1		place (State or Foreign intry) yland
			Usual Residence of Decedent 10a. State				
			Oe. Street and Number 4100 North Charles Street, #414 21218		10g.	Citizen of What Cou USA	ntry?
			11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 43 - 46	nt of Hispanic Origin? (Spe Cuban, Mexican, Puerto I No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: W	
			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual C (Give kind of work of life. DO NOT use if	done during most of workir retired)	ng	Egaland	•
		To Be Co	17. Father's Name (First, Middle, Last) David W. Sloan		(First, Middle, Maid		Judical
		ľ	19a. Informant's Name/Relationship (Type. Print) (Step- 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Marta H. Campbell Daughter) 6203 Mossway, Baltimore, Maryland 21212				
Baltimore,	Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name cemetery, crematory or other Rose Hill Cemet	er place)		. Location - City or To mberland,	
Balt	permit. Depart Import any Inj	2	21. Signature of Fundad Service Longee Martin U. Lawson 6500 You	ldwieDEFELD rk Road, Bal	FUNERAL H	HOME, INC. Maryland 2	1212
ivision of Vital Records, P.O. Box 68760,	or Attending Physician: The law requires that the death certificate be ter death. irector: After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the bur	er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Due to (or as a consequence of):		r respiratory arrest,		Approximate Interval Between Onset and Death
		edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unidentifying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				
		Certification: To Be Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (special contents)			23d. Date of deliv Month	very Day Year
			Part II. Other significant conditions contributing to death but not resulting in the underlying caus	se given in Part I.		couse contribute to t	the cause of death?
					24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of
			25. Was case referred to medical examiner? 1	2 EH/Outpatient 2 EH/Outpatient 3 DOA 1 Nursing Home 5 Agesidence 6 Other (Specify)			
			3 Suicide 4 Homicide 6 Could not be determined building, etc. (Specify)	ffice 2	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
5	To the Hospital c within 24 hours af To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death occurre	ed at the time, date	and place, and due t	to the cause(s)
•	To To	2	I den m	D57169.	29d.	Date signed (Month,	Day, Year)
	Sta	te	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Levy, M.D., 6701 North Charles Stree 31. Date filed (Month, Day, Year) 32, Registrar's Signature	et, Suite 51	05, Towso	on,MD 2120	4
	Registr		CER a a 2000 A. A. A. A. A.				

DHMH 17 Rev 1/2001

		State Registrar	aryland / Depa	artment of rtificate of			ne No.2009	28681
Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
/Medic		Leona Mae Stonesifer 4a. Facility Name (If not institution, give street and number)		4h City Town	and another of Dooth	Septmber	5, 2009	
Examin	er	1872 Blacksmith Drive			or Location of Death rriottsvil	16	4c. County of Dea	roll
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		rthplace (State or Foreign Country)
Director		234-46-6910 1□M 2□XF	77 Yrs.	Months Days	Hours Min.	Dec. 7,	1931	WV
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
e Maryli 3a-f sho	Director	MD Carroll	Too. Only, Town of Lo		rriottsvil	le		1 □Yes 2 □ No
with the		10e. Street and Number 1872 Blacksmith Drive		10f. Zip Code	21104	10g.	. Citizen of What C	*
death	Funeral	11. Marital Status 12. Was Decedent I	Ever in U.S. 13.		Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Evanities in the notified at once.	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, Give Year or Dates:	lo	lfYes,specifyCu 1⊡Yes 2 ∑ TNo		Rican, etc.)	Black, Whi	te, etc. White
21215-0036 d within 72 hours aft giana. Than "natural", or the "wedien Eventi	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occi	upation e during most of work	160). Kind of Business	s/Industry
ithin ne.	mple	Elementary/Secondary (0-12) College (1-4or 5	+) life.	DO NOT use retir	ed)	ing		
12-	ပိ	1 Z 17. Father's Name (First, Middle, Last)	Nurs	sing Ass	1		Nursing	
Baltimore, Maryland semit. Pages 1 and 2 should be file begartnent of Health and Mental Hymportant: If item 27 is marked othe iny injury or other traumatic event, once.	To Be	Elmer E. Sears				_{e (First, Middle, Mai} lyn Eliza	*	kley
Maryla 2 should n and Mer 1s marke raumatic		19a. Informant's Name/Relationship (Type. Print)			et and Number or Rui			
e, N 1 and Health em 27 ther t	. 7	Mrs. Kelly P. Johnson (Daug						
Mor Pages nent of nt: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo				c. Location - City o	
Baltir permit. P Departme Importan any Injury		4 th Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Lake View				ykesville	e, MD
Depa Depa Impo any li		Brian L. Haight	1400764 PC	Box 195	NEKAL HOME 5 Sykesvil	& CHAPEL le, MD 21	, P.A. 784	
S8760, ficate be executed Wedical Physician and physician and sthe burial-transit	dical Examiner	sque flor list controls but fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):	U De	y Dis.			Approximate Interval Between Onset and Death S y B
I Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 10 16 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnar	псу		23d. Date of do Month	elivery Day Year
rds, P	ρ	Part II. Other significant conditions contributing to death bu	t not resulting in the u	nderlying cause g	iven in Part I.		co use contribute	to the cause of death? Probably 4 Unknown
I Record The law requir sate has been s page 2 should	Completed					24a. Was an autopsy performed	prior to death?	
Vital F slcian: The certificate rector, pag	a	25. Was case referred to medical			26. Place of Deat	1 ☐ Yes 2 ☐	No 1 □ Ye	s 2□No
of Vita Physician: this certific	O B	examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatier	nt 3 DOA OI	her: 4 \Basel Nursing Ho		e 6 ☐ Other (Sp	ecifv)
Jn O	ii o	27. Manner of Death 1	y 28b. Time of Injury	28c. Inju		28d. Describe how i		
Division of Vital Records, To the Hospital or Attending Physician: The law requires th within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be dead of the funeral director.	Certification: To	2 Accident investigation	ry - At home, farm, str . (Specify)	M 15]Yes 2□No	28f. Location (Stree City or Town, S	t and Number or F tate)	Bural Route Number,
the Hospital hin 24 hours a the Funeral mpletely filled	Medical C	29a. Certifier (Check only one) Descritiying Physician: To the best of and manner sta	examination and/or in	h occurred at the vestigation, in my	time, date and place, opinion, death occur	and due to the caus red at the time, date	se(s) and manner a and place, and du	as stated. le to the cause(s)
Verthir Comp	Me	29b. Signature and title of certifier		29c. Licer	ise number	29d.	Date signed (Mor	nth, Day, Year)
		- 7 Che amon		1446	326	9	18109	
		Name and address of person who completed cause of de	eath (Item 23a) (Type,	Print) PO/Oset	DWIRLY	d Eldo	alwa.	MN 21784
Stat Registra		31. Date filed (Month, Day, Year) 32. Registra	r's Signature	Ked .		, , , , ,	- UI	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09 Year 1924 pm Day **Physician** /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number), 4c. County of Death Examiner 15c tar Mesa 100 toro If Under 1 Year 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Security Number **Funeral** Min 1 □ M 2 😿 F Months Days Hours Jouth Director Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar invaries notified at once. Director 1 ☐ Yes 2 X No lon 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2100 .J.A. dur Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tionis tral 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ೭ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son ore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - Lity or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 Pemoval from State まず 4 Donation 5 Dother (Specify) of Fune Service Licenses Service Bal Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Du-/ o (or as a conse uen cof): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont Month Year Day 5 ☐ Other (specify) been signed by the hould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertensian 3 ☐ Probabły 4 💆 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy perform hronic Rena Vital railure 2 No 1 □ Yes Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 2 ER/Outpatient 3 □ DOA Certification: To 1 Inpatient of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? or Attending 5 ☐ Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 2 ☐ Accident 1 Tyes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29b. Signature 29c. License number

State Registrar onth, Day, Year)

o completed callse of death (Item 23a) (Type, Print)

Registrar's Signature

		Please 1		llack Indelible Ink		•		
		for State	State of Marylan	d / Department of F Certificate of			2000	00000
_		Registrar 1. Decedent's Name (First, Middle, Last))	Certificate of		Reg. No Date of Death	KUU3	3. Time of Death
	siciar	PALLINE	SERGI			Month Da	Year O	2047 M
	edica mine	4		4b. City, Town, o	r Location of Death	4c	. County of Death	
Fune: Direct		5. Social Security Number 6. Sec. 219–30–3234			MORE If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Year) 6/30/16	SALTIMOR 9. Birthp Coun	lace (State or Foreign
ъ		Usual Residence of Decedent						
te Maryla 8a-f shov	Oicocio	10a. State 10b. County	N/A	, Town or Location Baltimor	e			0d. Inside City Limits 1≯□¥es 2 □ No
ath with the 23a or 2	1 i		-	10f. Zip Code	21230		tizen of What Coun Jnited St	
21215-UU36 I within 72 hours after death with the Maryland jene. Jene "natural", or items 23a or 28a-f show the Maryland show the Maryland Examination runt be refined at		3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ∐Yes 2 MNo If Yes, Give Year or Dates:	13. Was Decedent of I If Yes, specify Cub 1 □ Yes 2 No	dispanic Origin? (Specify an, Mexican, Puerto Rica Specify:	y Yes or No- an, etc.)	14. Race - Americ Black, White, e Specify: Wh	
v1215-0036 within 72 hours affiliene. r than "natural", or	Complete	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working d)		Cind of Business/Ind	
ed will hygien ther th	3		0 \	Office W			ns. Indus	try
Baltimore, Maryland 2 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other I any injury or other traumatic event, an	9	Domenico Sergi			18. Mother's Name (Fi Nunzia Pa		n Surname)	
h, Mary and 2 shoul ealth and M n 27 is marl ner traumati		19a. Informant's Name/Relationship (T) Nancy Ochrzcin /		19b. Mailing Address (Street 1341 Hull Str		ore MD 21	1230	
SAITIMORE, bermit. Pages 1 ar Department of Hes mportant: if item iny injury or othe		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State Sac	lace of Disposition (Name of emetery, crematory or other pla red Heart Of J		ry 9/9/20		more MD
bermit. Departimont	once.	21. Signature of Funeral Service Licens	eVictor P. Do	da,Jr ²² Name and Addre Charles 1501E. Fo	ess of Facility L. Stevens rt Ave., Ba	Funeral H ltimore M	Home, Inc	•
		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death					Approximate Interval Between
Physicia /Medic	_	Immediate Cause (Final disease or condition resulting in death)	a. HYPOTE Due to (or as a consequ	NSION pence of):				Onset and Death
Examin	ш.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ		E			
b, execute in and ial-transit	T vomimor	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	1	4		-	
58/50 tifficate be eg physiciar as the burit	-		d					
BOX seth cer attendin for use	Dhysicial/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₹ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3 Ectopic pregnand	ру		23d. Date of delive Month	ery Day Year
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ecord law require tas been si	Completed					24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
ITAL K. ifan: The l prtificate ha	٤					performed? 1 □ Yes 2 🖼 No	death?	2)No
OT VITA Physician: this certific	8	examiner?	Hospital:	f-B/O-ttit Off-BOA Oth	26. Place of Death (C		0.500	
On Or ding Phy h. After this funeral d	ion.	-	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury Wor	4 LI Nursing Home	5 Hesidence I. Describe how inju		у)
To the Hospital or Attending Pleast In 19 to the Hospital or Attending Pleast In 19 to the Funeral Director. After the completely filled in by the funeral	ortification.	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, factory, office		Location (Street a City or Town, Stat	nd Number or Rura e)	al Route Number,
Hospital 24 hours. Funeral	Caliba)	siclan: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occurred at the ti	ime, date and place, and opinion, death occurred	d due to the cause(at the time, date an	s) and manner as s	stated. o the cause(s)
To the within To the	Mo	29b. Signature and title of certifier	ATTENDING F	HYSICIAN 29c. Licens		29d. Da	ate signed (Month,	Day, Year)
		13dan	EMERGENC	Y PEPT HI	07370	00	05:	2009
101		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type, Print)		110 S Paca	ST BA	LTIMORE MP
	State istrar	CLU fl U coo-	37. Registrar's Signat	barles			*	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Michael R. Strempek September 6, 7:30 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Abingdon Harford 3719 Washington Avenue 8. Date of Birth (Month, Day, Year) Sept 16, 1 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☑ M 2 ☐ F Maryland 219-56-7118 57 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Middle Evantment in the hollified at once. 10a. State 10b. County 1 ☐Yes ※☐ No Director Abingdon Maryland Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21009 USA 3719 Washington Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 [Yes 2] If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Director / Manager State Of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara Mrozinski Henry Strempek ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3719 Washington Avenue Abingdon, Maryland 21009 Margaret Strempek, Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc.: 09/08/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility remation Society Of Maryland, Inc. 99 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or manifest shock, or heart failure. List only one cause og each line. Immediate Cause (Final Physician disease or condition resulting in death) Due lo (or a la consequence of) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 certificate has been signed by the a rector, page 2 should be detached it funeral director, this After t after death. filled in by the within 24 hours a To the Funeral C

Baltimore, Maryland 21215-0036

State Registrar nth, Day,

and mahner stated.

pleted cause of death (Item 23a) (Type,

296. Signature and title of certifier

n address o

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 23 Month AUG 2009 6:35 P M Takahashi Kenneth 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth Days Months Hours Min 1 M 2 □ F 29 Hawaii 79 JAN 1930 575-24-5529 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 1 ☐ Yes 2 ☐ No Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 United States 10005 Sterling Terrace 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Payes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: Japanese 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Judge 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bertha Noda Harry Takahashi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10005 Sterling Terr., Rockville, MD Marie Takahashi 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 B Cremation 3 ☐ Removal from State 9/1/2009 Beltsville, MD Chesapeake Crematory 9/1/2007 The Chesapeake Crematory Cremation Service Rapp Funeral & Cremation Service 933 Gist Ave., Silver Spring, MD 4 Donation 5 Other (Specify) 20910 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respritory Arrest disease or condition resulting in death) Due to (or as a consequence of) Asperation Due to (or as a consequence of) Alzhimer's Disease Due to (or as a consequence of): Parkinson's Disease 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

attending physician and for use as the burial-tran

certificate has been signed by the rector, page 2 should be detached

the Hospital or Attending Physician: Fin 24 hours after death. The Funeral Director: After this certifical Impletely filled in by the funeral director, p

within 2

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Completed

Be (

Certification: To

Medical

Department of Health Important: If Item 27 any injury or other transmote.

Physician

/Medical

Director

Funeral

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Be Completed

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Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a fire lical Examiner modified at

Pages 1 and 2 should be f nent of Health and Mental I tut: If Item 27 Is marked of

Baltimore,

Division of Vital Records, P.O. Box 687

08/23/09

KENNETH TAKAHASHI

Q

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Exami Physician/Medical IF FEMALE:

Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

1 Tyes 2 ThNo 3 Probably 4 Unknown 24a. Was an performed? 1 □ Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

5 Pending investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

D53691

29d. Date signed (Month, Day, Year) August 24, 2009

30. Name and address who comple ed cause feath (Item 23a) (Type, Print)

20852 3200 Tower Oaks Blvd., Rockville, MD Asay Reday, MD

State Registrar 31. Date filed (Month, Day, Year)



09-06926 Kevin Taylor Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day September 4, 2009 2300 hrs Medical Examiner Kevin Taylor

4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Baltimore Sinai Hospital Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Director 29 214-94-8355 1 XM Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County Yes 2 No BALTIMORE narked other than "natural", or items 23a or 28a-f shot event, the Medical Examiner must be notified at once. MD Director 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21215 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S. Armed Forces' 1 Never Married Married Yes Specify: BLACK 2 No specify: Yes, Give Year Yes Widowed Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) t. Pages I and 2 should be filed within 72 ho transit of Health and Menial Hygiene. reari: If item 27 is marked other than "naivor other traumatic event, the Medical Exa College (1-4 or 5+) Elementary/Secondary (0-12) LABORER 18.Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/2/5 NORTHWAY 203 BALTIMORE, MD MOTHER LOYOLA Date 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 12/2009 LANDS downe, MARY LAND Department o Important: injury or oth Other Specifi Donation 5 22. Name and Address of Facility 7he Signature of Funeral Se at caused the death. Do not enter the mode of dying, such as cardiac or respiratory 23a, Part I, Enter the disease, or complications Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Gunshot Wound of Head Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Year Live birth Fetal death nast 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions \$ Yes 2 V No 3 Probably 4 Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has death? performed? ✓ Yes 2 1 🗸 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 V Inpatient Other 4 Nursing Home 5 Residence 6 ER/Outpatient 3 1 Yes ٩ 28a. Date of Injury Sep 2, 2009 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Subject shot 1506 hrs Natural Yes 2 V No Pending 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 4402 Pimlico Road, Baltimore, MD determined (Specify) Local Street To the Funeral 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** within 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 5, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 2009 7:00 September 4, Nellie Gertrude Thompson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 2231 Knox Ave. Reisterstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 XF 28, 1920 212-78-1848 89 Maryland Director Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner mass be ruthed at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Directo Maryland Reisterstown Baltimore 10g. Citizen of What Country? United States 10f. Zip Code 10e. Street and Number 2231 Knox Avenue 21136 America of Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2∭∑No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes XXX No Specify Specify: ģ 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Matthews မှ Elizabeth Bull 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an 202 Leppo Road, Westmishter, Maryland 21158 Richard L. Troyer, Jr. (Grandson) timore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Sep. MXBurial 2 ☐ Cremation 3 ☐ Removal from State <u>+</u> 5 permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Carmel Cemetery 2009 Upperco, Maryland Sonatur of Funet of ervice 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21102 Charmil Dr. Manchester, MD 3296 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause or ach line. I mee ate Cause (i d sez e or condition resulting in death) ate Cause (Final arcinom **Physician** a /Medical Due o or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Ye ar for in the past 12 months? 1 ☐ Yes 2 ☐ No. Day Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 TYes : After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ž No 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Hospital or Attending Natural 5 Pending n 24 hours after death.

e Funeral Director; Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 2. Fo the 29d. Date signed (Month Day, Year) 29b. Signature and title of certifier 29c. License number

31. Date filed (Month, Day, Year)

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and

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SEP 99

ME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

MO

State

Registrar

NO 21204

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Erica Lanise Thomas September 2009 1745 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 29,1972 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖺 F 37 Director 379-76-9641 Michigan Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show direal Examiner must be notified at 1 ☐ Yes 2 No Director Anne Arundel Laurel MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20724 8224 Brushy Ridge Rd., Apt. 1A Funeral and 2 should be filed within 72 hours after death eath and Mental Hygiene.
n Z7's marked other than "natural", or items 23, ner traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 15 Wes 2 □ No 1992 − 17 Yes, Give Year or Dates: 2009 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Specify: African-1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) US Military 12 Cryptologist or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sylvester Ball Sandra Thomas ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If Item 27 is any injury or other traces Sandra Thomas / Mother 616 Mills Ave., Apt. 5, Pensacola, FL 32507 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Detroit Mem. Pk East | 9/17/2009 Warren, MI 22. Name end Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M01103 313 Talbott Ave., Laurel, MD 20707 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Decompensated Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Use to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 1∐ Yes 2√53No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient P 1 ☐ Yes 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After completely filled in by the funera 1 K Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D EXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year) MO 1067210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CmidSA, MD, 7300 Van Dusen Road, Laurel, MD 20707 Kon15

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) SEP 09

Division or Vital Records, P.O. Box 68760,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	For State Of Williams State Registrar	ai yiai iu		rtificate		eath		Reg. N	2000	28689
	Physicia	n/	1. Decedent's Name (First, Middle, Last)						2. Date of De Month		oay ⊸aYear	3. Time of Death
	Medic Examin	al	Mabel Irene Tester 4a. Facility Name (if not institution, give street and number)		. 1	4b. City,	Town, or	Location of Death	Septe		Der 1 Year Der 1 20 c. County of Deat	
			Citizens Nursin		Hom		WR		ace.		Har	ford
ı	Funeral Director			e (lin yes. lasi	t birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 8 / 28 / 1		Co	hplace (State or Foreign untry) rginia
	show dat	Ostal residence of Decedent 10a. State 10b. County 10c. City, Town or Location										10d. Inside City Limits
	Mary 28a-f notifie	Director	MD Harford	Abe	rdeer							1 🌠 Yes 2 □ No
	s 23a or oust be r	Funeral D	10e. Street and Number 602 Law Street			10f. Zip	Code 1001			-	Ditizen of What Co	untry?
936	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent 6 Armed Forces? 1 □ Yes 2 □ If Yes, Give Year or Dates.			Was Decede If Yes, speci 1 \(\subseteq \text{Yes} \) 2		spanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: Whi	e, etc.
2-0	2 hours "natur dical I	plete	15. Decedent's Education (Specify only highest grade completed)	- 1	16a. Dece	edent's Usua	l Occupa	tion uring most of work	ina	16b.	Kind of Business	
121	ithin 7; ene. r than the Me	Completed	Elementary/Seconday (0-12) College (1-4 or 5	+)	life. L	DO NOT use naker	retired)	anny moot or work	9		n Home	
Maryland 21215-0036	be filed w ental Hygi ked othel ic event, t	احدا	17. Father's Name (First, Middle, Last) Addie W. Pruitt					18. Mother's Nam	e (First, Middle, a B. Bl	Maide	n Surname)	
Mary	2 should Ith and Me 27 is marl r traumati		19a. Informant's Name/Relationship (Type, Print) Constance Colvin (Execut	or		ling Address 7 Law		nd Number or Rura Aber	al Route Numbe		or Town, State, Zip 21001	Code)
Baltimore,	Page 1 and nent of Heal ant: If item; ury or other		20a. Method of Disposition 1	20b. Pla	ice of Disp	osition (Nam	e of	!	Date	20c.	Location - City or	
Saltir	permit. P Departme Importar any Injur		21. Signat of Funeral see]пагт	2	2. Name and	Address	of Facility rgo Fune	ral Hom		<u>·</u>	<u> </u>
_			23a. Part 1. Enter the disease, or complications that caused	the death.		Aberde	en,	Maryland	<u> 21001</u>	<u>-33</u>	99	Approximate
	nysician/ Medical		shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition a	ita	the	rive		,, 333,1 43 34,14				Interval Between Onset and Death
	Examiner	J.	Due to (or as a	cutur	sign							
۱/	rted J ansit	Examiner	Siscumificity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	a conséquer								
*	ificate be executed ig physician and as the burial-transi	al Ex	resulting in death) Last Due to (or as a	consequer	nce of):							
760	icate b physic sthe b	dedical	d	to pov.	WI)							
Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed burns after death. Lu hours after death. Lu reral Director. After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal o	death 3	Cotopic p Other (spe		/			23d. Date of de Month	ivery Day Year
P.O.	s that the gned by se detacl	by Ph	Part II. Other significant conditions contributing to death b	ut not result		underlying c	ause give	en in Part I.	23e. Did to	obacco	use contribute to	the cause of death?
rds,	requires been sig hould b	eted	observe compulsive	01241	IVV_				11/			robably 4 Wunknown
Division of Vital Records,	Physician: The law r this certificate has i rral director, page 2 s	Completed	DANVERIUM								prior to death?	topsy findings available completion of cause of
ta	ician: certific ector, I	Be	25. Was case referred to medical examiner?				26. Pla	ce of Death (Check				
of V	ng Phys ter this neral dir	rte: To	27. Mannes of Death 28a. Date of Injure	ν 2	R/Outpatie 8b. Time c injury	ent 3 DO of 28	Bc. Injury work?	4 Lat Nursing Ho at	ome 5 Residence 5		6 Other (Specury occurred	ify)
sion	Attendir death. ctor: Af y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be			M reet factory	1 🗆 ነ	∕es 2 □ No	28f Location (S	Stroot a	nd Number or Rui	ral Boute Number
D X	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director. After thi completed filled in by the funeral		building, etc	. (Specify)					City or Tow	vn, Stat	e)	
/	the Hos in 24 hc he Fund ipleted	Medical	29a. Certifier (Check conly one) 3 Certifying Physician: To the best of examiner: On the basis of examiner on the basis of examiner on the basis of examiner. To the	kamination a	and/or inve	sti gation, i n m	ny opinior	n, death occurred a	t the time, date a	and place	e, and due to the	cause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier Mr 5WD 5 Mr Mr D			29c.	License 464	number		29d. D	ate signed (Month	, Day, Year)
			30 Name and address of person who completed cause of de	eath (Item 2	3a) (Type,		56	mp ·	21070		1-1	,
į	Stat Registra		11 10013	r's Signatur	· Asa	No. 8	/ 0	V 19	v ~ 5			

Tester Mabel

			1 _ State	epartment of Health and M Certificate of Death		WHILE ZEERI
			Registrar 1. Decedent's Name (First, Middle, Last)	Seruncale of Dealif	2. Date of Death	3. Time of Death
	Physicia /Medic		LEON CARL TETER	2	Month Da	3 2009 9:25 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	40	c. County of Death
2		Ш	Baltimore VA Medical Center [5. Social Security Number 6. Sex 7. Age (In yrs. last birth	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		AFT WOLF	rs. Months Days Hours Min.	04/26/193	36 West Virginia
	D		Usual Residence of Decedent	or Long-tion		10d. Inside City Limits
	//anyia	ō	10a. State 10b. County 10c. City, Town WV Berkeley	Hedgesville		1 □Yes 2X No
	r 28a-	Directo	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	th with		297 Warner Lane	25427	Un	nited States
	er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	 Race - American Indian, Black, White, etc.
35	thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Modical Evan, for must be confifed at	þ	1 □ Never Married 2 □ Married 1 □ Xfes 2 □ No If Yes, Give 3 🔀 Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: White
15-0036	72 hou	Completed	15. Decedent's Education 16a. ((Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work)	16b. F	Kind of Business/Industry
121	within 72 iene. than "na i h. Modic	dm	Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of workii life. DO NOT use retired) Fuck Driver		ransportation
22	Hyg ther nt, t	Be Co	4 Tr. 17. Father's Name (First, Middle, Last)		(First, Middle, Maide	
/lan	6 2 3 5 6	To B	Percey R. Teter	Sylvia	M. Reed	
Maryland	and and srr	ľ		Mailing Address (Street and Number or Rura	_	
	s 1 and 2 of Health item 27 i			2004 West End Dr., Orc Disposition (Name of crematory or other place)		o, Maryland 21226 Location - City or Town, State
ě	0 0 - <u>-</u>		1 □ SBurial 2 □ Cremation 3 □ Removal from State 4 □ Ponation 5 □ Other (Specify) Loudon	r Park Cemetery 09/10	/2009 Bal	Ltimore, Maryland
Baitimore,	permit. Pag Department Important: I any injury o		21. Signature of Figureal Service Ligensee	On Name and Address of Capille.		eral Home, Inc.
מ	83 = 53	0	W.V CSV	4107 Wilkens Avenue	, Baltimor	ce, Maryland 21229
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ot enter the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death
**	Physician /Medical		disease or condition resulting in death) Due to (or as a consequence of	preumonia		
	Examiner		Sancie	<i>y</i> -		
	pg iti	iner	Sequentially list conditions, if any heading to min a Junioration of the cause. Enter Underlying Cause (Disease or injury that initiated events	ŋ:		
(xecute and al-trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last C	f):		
8/60	death certificate be executed e attending physician and d for use as the burlal-transit	dical E	d.			
9	ertifical ing phy as th	Medi	IF FEMALE:	1 5-6		
X P P	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3 Ectopic pregnancy	19	23d. Date of delivery Month Day Year
9	the de	ysic	1 Yes 2 No 9 Unknown	5 Other (specify)		
ı, L	requires that the	by Pt	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
ğ	equire	ted t			1 □ Yes	2 No 3 Probably 4 Unknown
ပ္	e 2 sh	ompleted			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
-	n; The lificate have, page	O C O	25. Was case referred to medical	00 Pl (P II	1 ☐ Yes 2 ☑ N	lo 1 □Yes 2 □No
=	Physician: The law requires that the de this certificate has been signed by the ral director, page 2 should be detached	To Be	examiner? Hospital:	Othor	n <i>(Check only one)</i> me 5 ☐ Residence	6 ☐ Other (Specify)
n ot	ng Ph fter th	D: HO	27. Manner of Death 28a. Date of Injury 28b. Ti	· · · · · · · · · · · · · · · · · · ·	28d. Describe how inju	
20	ttendi deah. tor A	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm	M 1 Yes 2 No	39f Langting (Ctract of	and Number or Rural Route Number,
UIVISION	fter of the control o	Certification:	4 Homicide determined building, etc. (Specify)	n, street, factory, office	City or Town, Sta	
	To the Hospital or Attending Phys within 24 hours after deah. To the Funeral Trector After this completely filled in by the funeral dir		29a. Certifier (Check only (Ch	death occurred at the time, date and place,	and due to the cause	(s) and manner as stated.
	the H thin 24 the F mplete	Medical	one) and manner stated. 29b. Signature and title of certifier	29c. License number		Pate signed (Month, Day, Year)
	7 ₩ 6		Alimenter 1. 1811 18			09/03/2009
			30. Name and address of person who completed cause of death (Item 23a) (7	Type, Print)	57.5	29/03/2009 Saltimore, MD 2120
			THOMAS M PEMBROKE	MD 10 N Gree	ene St. 1	Baltimore, IND 2120
	Sta Registr		31. Date filed (Month, Day, Year) SEP 0 9 2009 SEP 0 9 2009 A. 4	barker		-
			OFLAND WARREND BY			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 6, 2009 **Physician** 10:30A M 7 T NN TEETS VIRGINIA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Pickersgill 8. Date of Birth NOV 1, 1911 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Min. West Virginia Months Days Hours 1 □ M 2/XF 97 233-34-4313 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location Examiner must be notified at 1 □ Yes 2 🕅 🏋 0 Director Baltimore Maryland Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 21204 USA 615 Chestnut Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes Ā[7] No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes XX No White Specify: ð Specify. XXWidowed 4 □ Divorced "natural", Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Public School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be innent of Health and Mental int: If item 27 is marked o George Zinn Effie May Austin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 155 West 68th St Apt 1214 New York, New York 10023 DTR Catherine Teets Davidoff 20a. Method of Disposition

XXIBurial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Dulaney Valley Mem Gardens | Sept 9,2009 | Timonium, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Family tchell-Wiedefeld Funeral Home Inc nature of Funeral Service License 6500 York Road Baltimore, Maryland 21212 diops that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 2 🗷 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed2 /es 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Inpatient 3□ DOA မ 2 ☐ ER/Outpatient 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 | Pending M 1 ∏ Yes 2 □ No Investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier

Division or Vital Records, P.O. Box 68760. after death. To the Funeral

Baltimore, Maryland 21215-0036

(Check only one) 2 Medical Examiner: On the basis of examination and/or inventor and manner stated.	estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
My Bothy Riley, up	D25205 September 7, 2009
30. Name and address of person who completed cause of death (Item 23a) (Type, P	N. Charles St. Bolts. Mi 21205
31. Date filed (Month, Day, Year) 32. Registrar's Signature	
SEP 0 9 2009 Sentira B. Span	le l

State

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 6:54 p^M HENRY LINWOOD September 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Examiner BALTIMORE 1309 GOODWOOD AVENUE BALTIMORE 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours **½CX**M 2□ F **Director** 59 FEB. MARYLAND 217-52-5204 23 1950 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertial Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examination in the rectified at 1 ☐ Yes 2X No Director MARYLAND BALTIMORE CO ESSEX 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code 1309 GOODWOOD AVENUE 21221 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married XX Married 1 ☐ Yes 2 XNo Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MARINE CONSTRUCTION PRIVATE 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ SEWELL TEMPLE MARY I STEVENS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patti S. Johnson/Wife 1309 Goodwood Ave., Baltimore, Maryland 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State CRESTLAWN MEM GARDEN\$ 09-04-09 MARRIOTTSVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Mobilica 22. Name and Address of Facility
WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A.
321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease. Immediate Cause (Final disease or condition resulting in death) /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-tran Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months? Month Dav Year 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown Completed

Physician Examiner

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

Physician:

has certificate Be Certification: To

24a, Was an 24b. Were autopsy findings available

						autopsy performed?	prior to completion of cause of death? 1 □Yes 2 □No				
25. Was case refer examiner?	red to medical		26. Place of Death (Check only one)								
1☐ Yes 2☐	No	Hospital: 1 ☐ Inpatient	t 2 ER/Outpatient	Home 5 Residence 6 ☐ Other (Specify)							
27. Manner of Deat 1 Natural 2 Accident	5 ☐ Pending investigation			М	28c. Injury at Work? 1 □Yes 2 □No	28d. Describe how injury	occurred				
3 ☐ Sulcide 4 ☐ Homicide	6 Could not be determined		y - At home, farm, stre (Specify)	et, facto	ory, office	28f. Location (Street and City or Town, State)	Number or Rural Route Number,				
29a Certifier	1 Cartifying Ph	vsician. To the hest of	my knowledge death	OCCUPE	ad at the time date and nla	ce, and due to the cause(s).	and manner as stated				

29a. Certifier (Check only one)	Certifying Physician: To the best of my knowledge, death occ 2 Medical Examiner: On the basis of examination and/or investigand manner stated.		
OOL Clanates an	-l aial4aifi	20a Lisanna mumbar	20d Date signed (Manth Day Year)

	Eloonio Hamori	
De full res	D40854	

9/3/2009

30. Name and	address	of person	who	completed	cause	of death	(Item	23a)	(Type,	Print
	,	4-					_		_	

Dund Riseb	25	27 St	Paul	Place	Bultimore	21202
31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture				

State Registrar

within 24 hours after death

To the Funeral Director:
completely filled in by the

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra 869 Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 45 1 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death OAK CREST PARKVILLE BALTIMORE 8. Date of Birth (Month, Day, JAN . 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Min. 1 □ M 2X F Months Days Hours 96 3,1913 MARYLAND 213-12-6589 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No MD PARKVILLE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4400 MARBLE HALL ROAD 21218 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🕅 No Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√☐ No Specify. If Yes, Give Year or Dates: Specify: WHITE 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PHILIP MALLEK SOPHIE RAKOWSKI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THEO KARPOVICH/ NIECE 2305 MAYFIELD AVENUE, BALTIMORE, MD. 21213 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HOLY ROSARY CEMETERY 9/11/09BALTIMORE, MARYLAND 22 Name and Address of Facility LILLY & ZEILER INC. 21. Signature of Funeral Service Licensee FUNERAL HOME EASTERN AVENUE, BALTIMORE, MD 1901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate date. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes ~2 □No 1 ☐ Yes 2- No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. 28d. Describe how injury occurred Injury at Work? 1 Natura 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, certificate be O. σ. I or Attending I after death.

Division of Vital Records, THURSA JAMET Hospital To the Hosp within 24 hou To the Fune completely fi

> State Registrar

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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traumatic event, the Medical Examiner must be notified at

and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

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31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifie

1462

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) myenten

and manner stated.

32. Registrar's Signature

park

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

5800

29d. Date signed (Month, Day, Year)

09-06874 Yi-Ya Tian Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

Yi-Ya Tian	1-	Sta For State	ate of Ma	aryland / D	epartr) <i>Certifi</i>	ment of l icate of i	Health an Death	id ivienta	Hygien	e Reg. I	No.	1011	9 2869
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, MD and 2 sho ealth and em 27 is	-	20a. Method of Disposition				ace of Dispos	sition (Name of	cemetery,	Date	Э	20c. Locatio	n - City or	Town, State
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altimore, mit. Pages I ar epartment of He portant: If ite	ŀ	4 Donation 5 Other 3 21. Signature of Funeral Service	specify: e Licensee T	homas G									and 21228
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Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t		29a. Certifier (Check only one) Certifying Medical	g Physician: Examiner: Or	To the best of m			curred at the tir	me, date and p	place, and du occurred at th	e to the cau	ise(s) and ma e and place,	anner as st and due to	tated. the cause(s)
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Baltimore,	97 0		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation	3 ☐ Removal from State	20b. Place of Dispo cemetery, crei	sition (Name of natory or other place)	Date	20	Oc. Location - C	City or To	wn, State
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	Physician: The la r this certificate has ral director, page 2	2	examiner? 1 ☐ Yes 2 ☐ No		nt 2 ER/Outpatie	nt 3 ☐ DOA Other: 4 ☐	Nursing Home	5 Residen	ce 6 □Othe	r <i>(Specif</i>)	()
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Division of	Hospital or A 4 hours after (Funeral Direc tely filled in by	Certification:	4 ☐ Homicide determ	building, etc			0	ity or Town,	State)		l Route Number,
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Elizabeth Whitmore 11:00 September 6 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Copper Ridge Sykesville Carroll 8. Date of Birth (Month, Day, Year)
Dec. 18, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🔀 F Yrs. Maryland 1915 Director 93 <u>212-03-7786</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a five less than it an inventional and 1 X Yes 2 ☐ No Director Carroll Sykesville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21784 710 Obrecht Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White <u>۾</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 teacher public school 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I Grace Leona Biehl ၉ George Ruthford Straw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 24 N. Court St. Westminster, MD 21157 Jeffrey D. Scott/ attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/11/2009 | nr. Linwood, MD Pipe Creek Cemetery 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Ligens 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that all sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final **Physician** mente disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): I or Attending Physician: The law requires that the death certificate be executed after death.

after death.

Director: After this certificate has been signed by the attending physician and birector; by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d, Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a

To the Funeral I 29a. Certifier 1Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29

Registrar
DHMH 17 Rev 1/2001

State

21215-0036

Marviand

Baltimore,

Box 68760,

P.O. I

Division of Vital Records,

2. Registrar's Sign

WARFIELD

Certificate of Death

2. Date of Death

3. Time of Death

3:12 A M

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Physician /Medical **Examiner** For State Registrar

1. Decedent's Name (First, Middle, Last)

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uires that t signed by Ild be deta	ρ	Part II. Other significant conditions MEDIASTINAL		sulting in the underlyin	ng cause given in Part I.	23e. Did tobaco
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s certificate director, p	Be C	25. Was case referred to medical			26. Place of De	eath (Check only one)
	P B	examiner? 1 Yes 2	Hospital: 1 Inpatient 2	DOA Other: 4 - Nursing	Home 5 Residence	
iding Phy ith. After this e funeral (27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how is
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Hospita 24 hours Funeral letely fille	Medical C		hysician: To the best of my kno aminer: On the basis of examina and manner stated.			
omp	Me	29b. Signature and title of certifier	Λ	. 2	29c. License number	29d.
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		30. Name and address of person who		m 23a) (Type, Print)		
		MANJUNATH MA	RKANDAYA		600	North Wolfe
Sta Regist		31. Date filed (Month, Day, Year) SEP 0 3 20	32. Registrar's Signa	ature	9	

SEPTEMBER 03 2009 (FERARD LDWARD 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Aug 9, 1950 MD 10d. Inside City Limits 1 ☐ Yes 🕏 ☐ No 10g. Citizen of What Country? 14. Race - American Indian Black, White, etc. Specify: White 16b. Kind of Business/Industry Engineering 18. Mother's Name (First, Middle, Maiden Surname) Bernadette Graziani 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6574 Guilford Road Clarksville, MD 21029 20c. Location - City or Town, State Woodstock, MD 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL MCONG9 | PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

3 DAYS 23d. Date of delivery o use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No No 6 Other (Specify) jury occurred and Number or Rural Route Number, e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year) EFTEMBER 03, 2009 St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** William H. Weber 1140 A 09-02-2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ▼M 2 □ F 213-20-1445 03-29-1927 Director 82 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at MD 1 ☐Yes 2 ▼ No Harford Director Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1218 Bancroft Ct 21014 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ∐Yes 2 No Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, the Mede. once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Weber Frances Lakota ၉ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Weber (Wife) 1218 Bancroft Ct Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Mem. Gar. 09-05-2009 4 ☐ Donation 5 ☐ Other (Specify) Fallston, MD 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (s a consequence of) signed by the attending physician and be detached for use as the burial-transit stage Due to (or as a conse Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) I ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Funneral Director. After this certificate has been sign completely filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 ☐ No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 Natural

2 Accident 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar ALBERT S 31. Date filed (Month, Day,

Harford Road, Suite 105, Fallston, MD 2109;

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Phys /Me Exa

Fune Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at

Baltimore, Maryland 21215-0036

Physicia /Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		1 - State Registrar				Cer	tificate of	Death	1		Reg. No.	2009	400	ככנ
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xamin	er	4a. Facility Name (If I Saint		, give street and nu on Medic		ter	4b. City, Town,		of Death	on	4c.		timore	
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any injury or other traumatic event, the Medical Examiner must be notified at once.	0	MD	BALT	IMORE	DID	GELEIG	u				1 □Yes 2 🙀 No			
ooth	Director	10e. Street and Numi		IMORE	NID	GELETA		10g. Citizen of What Country?						
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J. C.	шc									auto perf	opsy ormed? 2 M No		ompletion of cau	use of
ž 5		25. Was case referre	ed to medical					26 Pla	re of Death	1 ☐ Yes	-/-	o 1 ∐Yes	2 🗆 No	
	o Be	examiner? 1 ☐ Yes 2 ☐		Hospital:	Inpatient 2 🗆	ER/Outpatier	t 3 DOA O	thor:		,		6 ☐ Other (Spec	cify)	
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			State of Maryland / Dep	artment of Health and Mertificate of Death		211114	28700	
			Registrar 1. Decedent's Name (First, Middle, Last)	Tillicate of Death	Reg.	No. 1- 0 0	3. Time of Death	
	Physici /Medic		Ann M. Walker		sept. 6	Day 2009 Year	8 am м	
	Examin		4a. Facility Name (If not institution, give street and number) 1319 E. Biddle St.	4b. City, Town, or Location of Death Baltimore	9	4c. County of Death	/a	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 215 78 8586 1 M 2 F 61 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye June 17	9. Birthplace (State or Foreign Country)		
	τ		Usual Residence of Decedent					
	iarylai show	ō	10a. State 10b. County 10c. City, Town or L	ocation Ltimore		10	d. Inside City Limits 1	
	the N	rect	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Counti	Λ	
	h with	al D	1319 E. Biddle St.	21213		USA		
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Pacifical Exprise must be invited once.	y Funeral Director	1 Never Married 2 Married 1 S No	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2 ☐ No Specify:	cify Yes or No- Rican, etc.)	14. Race - America Black, White, et	c.	
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and	be file	Be	17. Father's Name (First, Middle, Last) Benjamin Walker	18. Mother's Name	(First, Middle, Maid B. Hub	· ·		
Maryland	should nd Mei marke	잍		ing Address (Street and Number or Rura			Code)	
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387		dical	d					
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and place, investigation, in my opinion, death occurr	and due to the caus ed at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier Fellow in	29c. License number	29d.	Date signed (Month, D	lay, Year)	
			Muchaela Highers Medical Oncol	ofy AT4147357		7/8/200	9	
			30. Name and address of person who completed cause of death (item 23a) (Type,					
	Sta	e.	MICHAELA HILLO INS. 40 N BROADWAY, B. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ALTIMORE, 21231				
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	_		Registrar 1. Decedent's Name (First, Midd	fle. Last)			uncate or i	Dealli		2. Date of De	Reg. No	. C. U U J	3. Time of Death	1
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-	/Medic Examin		Janet M. Wri 4a. Facility Name (If not institution		nber)		4b. City, Town, or	r Location of		Septem		5, 2009 County of Death	9.40 A	-
-	LXumm		St. Joseph's	Nursing H	ome		Catons	ville			E	Baltimore	1	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	th ay, Year)	9. Birthp	place (State or Foreign	7
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960	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Natical Examiliar must be rediffied at once.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	rried Armed For	2 🔀 No ∕e		Was Decedent of H f Yes, specify Cuba 1 □Yes 2⊠No	lispanic Ori an, Mexicar Specify:		cify Yes or No lican, etc.)	-	14. Race - Americ Black, White, Specify: W		
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ita	sician; Th certificate rector, pag	Be C	25. Was case referred to medica examiner?	af				26. Place	of Death	1 ∐Yes (Check only o		7 10163	2,410	_
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isio	vttendi death. ctor: A y the fu	icat	3 ☐ Suicide 6 ☐ Could	not be	of Injury At he	mo form str		Yes 2□	-	Of Logotian (Ctanata	and Advantage on December	of Flavia Musebas	_
Division	after after Direction by	Certification: To	4 ☐ Homicide determ	nined 28e. Place buildir	ng, etc. (Specif	y)	eet, factory, office		28	City or Tov	vn, State	nd Number or Run e)	M Houte Number,	
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 12 Certifyl 2 Medica	ng Physician: To the I Examiner: On the ba and mann	asis of examina	wledge, deatl ation and/or in	n occurred at the tir vestigation, in my o	me, date ar pinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(s	s) and manner as s d place, and due to	stated. o the cause(s)	
1	To the To the To the Comple	Me	29b. Signature and title of cortific				29c. Licens	e number			29d. Da	ate signed (Month,	Day, Year)	
		1	▶ 8.	while	w		D	321	58			9/8/09		
			30. Name and address of person	who completed caus	e of death (Item	n 23a) (Type,	Print)	ad S	te lo	8 (0)	for &	willo.M	Day, Year)	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #26, per MD g895 9/9/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September 7, Physician Year 2009 9:30 P.M Grace LaRue Zepp /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Golden Crest Assisted Living Hampstead 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2XX 217-01-9732 Dec. 9, 1919 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXNo Director Maryland Carroll Hampstead 10g. Citizen of What Country? United States 10e Street and Number 10f. Zip Code 1811 Albert Rill Road 21074 America 14. Race - American Indian, Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🍇 No Specify. ģ Specify: White XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th <u>Seamstress</u> Tailor's Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry McKinley Ruby ပ္ Nannie Marie Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any Injury or other trau Ethel M. Watkins (Sister) 2706 Sharon Road, Jarrettsville, Maryland 21084 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Sep. 11, MXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Manchester, Maryland New Lutheran Cemetery 2009 of Finance Service Line 22. Name and Address of Facility Eckhar It Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury) that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exam physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Feta! death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b autopsy performed 1□ Yes 2□ No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Assisted Living Other: 4 Nursing Home 3 Aresid 1 ☐ Yes 2 No <u>o</u> 2 ER/Outpatient 3 DOA this 6X Other (Spec 28a. Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation Injury hours after death. uneral Director: Af ely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) un 24 hou...
the Funeral Dire... 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

101

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State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Her Next D. Hernd P(SUN Dr. MN 2973 M44C

32. Registrar's Signature

hester Rd Man chaster MN 21/62

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 4:05 P 08 2009 Paul Donald Acker /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 0 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1**⊠**м 2□ F 221-50-9914 16, 1955 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examinat must be motified at 1 ☐ Yes 2 X No Director Delmar Wicomico MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with U.S.A. 104 Woodlawn Avenue 21875 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: \$ 3 Widowed 4 Divorced white Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Microwave Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Donald Henry Acker Charlotte Stever ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Karen K. Sowell (Sister) 1201 Maple Street Delmar, MD 21875 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 25, 2009 Delmar, Maryland Melsons Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee 13 E. Grove Street Delmar, DE 23a. Part 1. Enter the disease, complications that it is sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or he int failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MRTASTATIC PRRITONBAL MRSOTHBHOMA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a nonsequence of Examiner If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No detached 9 | Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 □Yes 2 □No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death.

Funeral Director: After this completely filled n by the fureral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 72 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and hile of certifier Name and a Fress of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 2 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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/N	ledic	a
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Phys /Me Exar

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 2.4 hours after death. Division of Vital Records, P.O. Box 68760,

in al	Decedent's Name (First, Midd.			· · · · · · · · · · · · · · · · · · ·				2. Date of Deat Month	Day	Year	3. Time of Death	
_	Margaret A							August			2:05 P	
er	4a. Facility Name (If not institution	. 0	,		4b. City,		ocation of Death		4c. (County of Death		
	Solomons Nur						mons			Calver		
	5. Social Security Number 578–14–6685 Usual Residence of Decedent	6. Sex 1 □ M 2 🖾 F	7. Age (In yrs. 94	last birthday) Yrs.	If Under Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	L 91 5	9. Birti	nplace (State or Fore untry) DC	
1	10a. State 10b. County	,	10c. Cit	y, Town or Lo	ocation						10d. Inside City Lim	
ō	MD C	alvert	I	usby							1 □Yes 2🌠	
Funeral Director	10e. Street and Number				10f. Zip	Code		10g. Citizen of What Country?				
	12705 Blair	Road				206	57					
nerg	11. Marital Status	12. Was De	cedent Ever in U.	S. 13.	Was Dece		panic Origin? (Sp., Mexican, Puerto	ecify Yes or No-		S.A. 14. Race - Amer		
by Fu	1 Never Married 2 Mar	If Vos C	2 🔯 No Bive		1 ☐ Yes 2		Specify:	Hican, etc.)		Black, White Specify: Whi		
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lete	15. Deceder (Specify only highe	nt's Education est grade completed)	(Give		rk done du	ırina most of worki		16b. Kir	nd of Business/I	naustry	
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	17. Father's Name (First, Middle,	. Last)		1			18. Mother's Name	e (First, Middle, I	Maiden 3	Surname)		
o Be	Frank Thibeadeau Nora Hutchinson									,		
၉	19a. Informant's Name/Relations			19h Maili	na Address	(Street a	nd Number or Rur			r Town State 7	in Code)	
	Bruce Andres		andson				m Circle					
	20a. Method of Disposition		20b. F	Place of Disponentery, cre	osition (Nan	ne of	, [Date	20c. Lo	cation - City or	Town, State	
	1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		n State i	dar Hi				1/2009	Su	itland,	MD	
1	21. Signature of Funeral Service										ert, P.A.	
	Pary J. Go	ff					ern Md B					
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e.	Sequentially list conditions, if any, leading to finine date Due to (or as a consequence of).											
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 19 2009 2009 **Physician** 9:50 A M В. ANDERSON LILLIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE PATUXENT RIVER HEALTH & REHAB LAUREL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 09-30-1930 **Funeral** Min. 1 □ M 2 🔀 F Months Days Hours SOUTH CAROLINA 579-36-2086 78 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examinar must be notified at once. Y□Yes 2□No Director WASHINGTON DC 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20002 U.S.A. 24 SEATON PL NW Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □Yes 21 If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify. 2 BLACK 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE DIETARY MANAGER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN MOYD ဂ္ BESSIE L. TISDALE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JACQUELINE ANDERSON/DAUGHTER 7554 SOUTH ARBORY LANE LAUREL, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State GLENWOOD CEMETERY 08-27-2009 WASHINGTON, DC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a. CEREBROVASCULAR ACCIDENT /Medical Due to (or as a consequence of): Examiner ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year ☐Yes 2XNo 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed I Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2**X**INo 1 ☐Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death neral Director: / filled in by the f 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 8-20-2009 D24721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 14333 LAUREL BOWIE RD SUITE# 208 LAUREL, MD 20708 SADIQ, MD 32. Registrar 31. Date filed (Month, Day, Year) State AUG 2 5 2009

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Barley Kathleen Yvonne August 26, 2009 2130 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Allegany 1701 Bedford Street Cumberland If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 □ M 2 🔯 67 02/01/1942 Maryland 220-38-0787 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 DYYes 2 □ No MD Allegany Cumberland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1701 Bedford Street 21502 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 2 X No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💢 No Specify Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lindner Margaret Lucile Andrew Lawrence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21502 A Street, LaVale, Maryland Michael P. Barley / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signatur of Juneral Service Licensee
Adams Family Funeral 22. Name and Address of Facility State Anatomy Board Baltimore, Maryland P Home. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nough disease or condition resulting in death) Due to-(or as a consequence of): 0 Sequentially list conditions, in any, reading to minimal accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dius to (cir as e donsequence Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2 ☐HO 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

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Funeral

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Completed

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?7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the M. o'cal Eversing must be notified at

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

al Hygiene.

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Health em 27 i

permit. Pages 1
Department of IImportant; If ite
any injury or ot
once.

other

altimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Examiner **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. physician and s the burial-trans Physician/Medical attending p for use as t certificate has been signed by the rector, page 2 should be detached ģ Completed director, Be Certification: To After

Director:

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

23b. Was decedent pregnant in the past 12 months? 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 🗆 Yes

1 □Yes 217 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

autopsy performed

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier 29c. License number

and manner stated.

Hospital:

5 Pending investigation

6 ☐ Could not be

determined

D0054411

29d. Date signed (Month, Day, Year) August 27, 2009

Ru. Lw FD 30. Narp and address of pus n who completed cause of death (Item 23a) (Type, Phnt)

Beverly 500 Memorial Avenue, Cumberland, MD Calkins, M.D., 21502

State Registrar

Medical

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** BULLOCK LIZZIE MARY 2009 3:02 AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S 2003 CONNOR COURT UNIT K MITCHELLVILLE If Under 1 Year | If Under 24 Hrs. Social Security Number . Age (In vrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 □ ¥ 102 IOWA Director 577-26-9516 _11_1907 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State d other than "natural", or items 23a or 28a-f sho event, the Madical Evantier must be notified at 1X Yes 2 No DC WASHINGTON Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 should be filed within 72 hours after death with and Mental Hygiene.
Is marked other than "natural", or items 23a or U.S.A. 20020 4229 FT. DUPONT TERRACE SE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: BLACK ð 3 x Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th NURSE PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES WARD traumatic ပ BERTIA ANDERSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any Injury or other traur once. CHARLYN RICHARDSON/GRANDDAUGHTER2003 CONNER COURT UNIT K MITCHELLVILLE, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-29-2009 4 ☐ Donation 5 ☐ Other (Specify) HARMONY MEMORIAL LANDOVER, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOMYOPATHY /Medical Due to (or as a consequence of): Examiner DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) HYPERTENSION sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ned by the a □Yes 2X No 9 Unknown 9 Unknow s been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform certificate 1 □Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) BAUGHTER Hospital: Other: 4 Nursing Home 5 Residence 6 1 Other (Special 1∐Yes 2∭INo 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

the death certificate be executed Box 68760, P.O. The law requires that Division of Vital Records, Attending Physician; Hospital or Attendi 24 hours after death. Funeral Director: A

Maryland 21215-0036

Baltimore,

To the within 2

death.

24 hours

31. Date filed (Month, Day, Yea AUG 2 5 2009 State Registrar

Medical

2 Accident

3 Suicide

29a. Certifier

29b. Sign

4 Homicide

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER A. SWABY M.D.

6 ☐ Could not be

d title of certifie

determined

4005284

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

4000 MITCHELEVILLE ROAD SUITE B422 BOWIE, MARYLAND

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

ind manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			for State	State of Maryland				lental Hyg	giene	2009	28708
			Registrar		Cei	rtificate of	Death		Reg. No.	- 0 - 7	
	Physici	an	Decedent's Name (First, Middle, I	1				Date of Dea Month	Day	Year	3. Time of Death
	/Medic			BROWN				8	23	09	18-35 A-M
	Examin	er	4a. Facility Name (If not institution,	· · · · · · · · · · · · · · · · · · ·	v. 1	Chever1	or Location of Death			ounty of Death .nce Geo	rgets
			00 0100	2GES HOSPITA		If Under 1 Year	•	8. Date of Birtl			place (State or Foreign
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	pu k		Usual Residence of Decedent 10a, State 10b, County	10c City	y, Town or Lo	cation					10d. Inside City Limits
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	28a-f	Director	10e. Street and Number	George S nya	LLSVII	10f. Zip Code			10a Citize	en of What Cou	- AL
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	eath	Funeral	4506 Buchanan St	. Unit I 12. Was Decedent Ever in U.S	S 13	20781 Was Decedent of I	Hispanic Origin? (Sr	pecify Yes or No-		I. Race - Americ	
	iter d	ᇤ	1 ☐ Never Married 2√√ Married	Armed Forces?	10.	If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)		Black, White,	
2	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, if he Medical Ever, if net coust be rectified at	þ	3 ☐ Widowed 4 ☐ Divorced	d 1 ∐Yes 2 ☑ No If Yes, Give X Year or Dates:		1⊡Yes 2√∏No	Specify:		s	Specify: Bla	ack
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<u> </u>		Be (17. Father's Name (First, Middle, La				18. Mother's Nam		Maiden S	urname)	
yland	uld b Ment arked	2	Frederick Barks	sdale			Regina	James			
Mar	2 should be and Menta is marked aumatic ev		19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Numbe	er, City or	Town, State, Zij	p Code)
	of Health Item 27		George E. Brown				St Hyatt				
9			20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 3			sition (Name of natory or other pla		Date		ation - City or To	
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Бапптоге,	permit. Page Department (Important: If any injury or once.		21. Signature of Funeral Service Do	censee			ess of Facility Fo				
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State Registrar

AyaHsville MD 20785

Division or Vital Records, P.O. Box 68760.

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H ertificate of I			ene 1. No. 2009	28709
	=		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death	Day Year	3. Time of Death
	Physici /Medic		ARTHUR BRIDG	GETTE JR.				AUGUST 2	Day Year 1, 2009	6:15A M
×	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Deat	h
1		¥	4811 70th PLACE			HYATTSVI			PRINCE GI	EORGE
	Funeral Director		227-48-9854	TXM OF E	e (In yrs. last birthday 70 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	/ear) 9. Birtl Co VIRC	nplace (State or Foreign untry) SINIA
	ryland how Lat		Usual Residence of Decedent 10a. State 10b, County		10c. City, Town or L	ocation				10d. Inside City Limits
	e Ma 3a-f s	Director	MD PRINCE (EORGE	HYATTSVII	LE				1 X Yes 2 □ No
	or 28	Dire	10e. Street and Number			10f. Zip Code		10g	g. Citizen of What Co	untry?
	ath w	ra	4811 70th PLACE			20784			U.S.A.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	d by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	Ever in U.S. 13	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: BLA	e, etc.
5-(72 h "natu dical	ete	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dec (Giv	edent's Usual Occupa e kind of work done o DO NOT use retired	ation djuring most of workii	ng 16	6b. Kind of Business/	Industry
121	within iene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5)+)	ONSTRUCTI			PRIVATE	
	filed Hyg other ent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	aiden Surname)	
lan	should be filed wand Mental Hygies marked other tumatic event, th	To B	ARTHUR GARFIELD E	RIDGETTE	SR.	Į	MAGGIE ST	ARKS		
Maryland	2 shou and N Is mai		19a. Informant's Name/Relationship (7	Type. Print)	19b. Mai	ing Address (Street a	and Number or Rura	al Route Number, (City or Town, State, 2	(ip Code)
	1 and 2 Health Jem 27 I		SARAH BRIDGETTE/W	IFE	4811	70th PLA	CE HYATTS	VILLE, M	D_20784	
ore			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		ematory or other plac	(e)		Oc. Location - City or	Town, State
Ē	Pages ment of I		4 Donation 5 Other (Specify			TION CEME			LINTON, MI	
Baltimore,	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licent	see		22. Name and Addres 474 LANDO			FUNERAL HO MD 20785	ME
	#.		23a. Part1. Enter the dispase, or comp shock, or heart failure. List only	plications that caused one cause on each li	I the death. Do not en	nter the mode of dyin	g, such as cardiac o	or respiratory arres	it,	Approximate Interval Between
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7	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
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-	ertific ing p	Mec	IF FEMALE:							
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of del Month	ivery Day Year
	s that ned b	by Pt	Part II. Other significant conditions of		ut not resulting in the	underlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ğ	equire en sig ould b		Diabet	es				1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown
Vital Records,	e law re has bee	Completed	Hypert	Tension	,			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
Ä	The page	mo.						performe	ed? death?	·
İta	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Death			
or V	his i dir	To I	1 Yes 2 No		ent 2 ER/Outpatie		4 LI Nursing Hor	me 5 Residen	ce 6 □Other (Spe	cify)
ion	nding Ph tth. r: After th e funeral	ation:	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry Year) 28b. Time Injury	Worl	yat k? Yes 2 ∐No	28d. Describe how	injury occurred	
Division	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director, After t completely filled in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injuding, et	ury - At home, farm, s c. (Specify)	treet, factory, office	2	28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
	e Hospit 1 24 hours le Funera	lical	(Check only 2 Medical Exan	niner: On the basis o	of my knowledge, dea f examination and/or ated.	nvestigation, in my o	pinion, death occurr	red at the time, dat	te and place, and due	to the cause(s)
	To the To the comp	Me	30. Name and address of person who salvador Sylvador Sylv	Alres	to 00	29c. License	e number	290 A	d. Date signed (Mont	h, Day, Year)
R	10		30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	Print)	1708.	Leven	10 MA.	reland
	⊕ Sta	ite	31. Date filed (Month, Day, Year)	32. Regist	ar's Signature		1	V	71	
F	Registi	ar	AUG 2 5 2009 /	enera & A	7				· · · · · ·	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First; Middle, Last) August 1735 **Physician** 01 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, JULY 26 9. Birthplace (State or Foreign Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2X F COLORADO 46 Director 215-88-7173 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location at 1 XYes 2 No BOWIE PRINCE GEORGE'S MD Director injury or other traumatic event, the Medical Examiner must be notified 10a. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 12624 QUAKING BRANCH COURT 20720 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo 1 Yes If Yes, Give 1 ☐ Never Married 2 ☐ Married Specify: BLACK Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done d life. DO NOT use retired) during most of working (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE REAL ESTATE AGENT 2 YRS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUISE MAE COOPER THURMAN L. BATTLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 12624 QUAKING BRANCH COURT BOWIE, MARYLAND 20720 Department of Health an Important: If item 27 is any injury or other trau GLADYS M. BATTLE/STEP-MOTHER 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MARYLAND RESURRECTION CEMETERY 8/22/2009 J. B. JENKINS FUNERAL HOME 21 Signature of Furieral Service Live 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND Part 1. Emir the disealer, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi and Due to (or as a consequence of) attending physician P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy Year Dav in the past 12 months? Pregnant at time of death Month 5 Other (specify) 1 ☐ Yes 2 No the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 20 1 Tes 26. Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be Other: 4 \square Nursing Home Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient မ 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, e Hospital of 24 hours a To the lawithin 2

State Registrar

LONNY 31. Date filed (Month, Day, Year) AUG 2 5 2009

29b. Signature and title of certifier

29a. Certifier

(check only

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YAZMUS 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

State Registrar

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Walter

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Accident MD k. Noumann. 32. Registrar's Signature banko

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Otate of Me	ai yiai iu	-	tificate of	Death		g. No.	009	28713
	Physici	ian	Decedent's Name (First, Middle, La	st)					2. Date of Deat Month	Day	Year	3. Time of Death
\	/Medic		Alvin M. Bender 4a. Facility Name (If not institution, given	e ctreat and number)			4h City Town o	r Location of Death	August	-	2009 ounty of Death	10:10 A ^M
1.	Examir	ner	Goodwill Mennonit	ŕ			Grantsvi					
	Funeral		5. Social Security Number 6. S		e (In yrs. las	st birthday) Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Sept • 6	Year) o	9. Birth	place (State or Foreign Intry) yland
	Director		212-38-6514 Usual Residence of Decedent						bept. 0	, 10	ZZ Mar	yrana
	how lat	L	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
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	ns 23	Funeral Director	1546 Springs Rd.	12. Was Decedent E	Ever in U.S.	13. V	21536 Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	USA 14.	Race - Ameri	can Indian.
136	in 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show adical Examiner must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:			fYes, specify Cuba I⊡Yes 2█X No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)		Black, White	
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7	be filed within 72 ho ital Hygiene. Id other than "natu event, the Medical	Completed	(Specify only highest grant Elementary/Secondary (0-12)	College (1-4or 5-				during most of work d)	I .			
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<u> </u>	l be fil ntal H ed otl	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			rname)	
	2 should be and Menta is marked raumatic ev	은	Milton E. Bender 19a. Informant's Name/Relationship	Time Print)		10h Mailin	a Address (Street	Savilla and Number or Rui	N. Maust		own State 7	in Cada)
Ĕ	and 2 sealth ar n 27 is ier trau		Martin R. Bender/					Rd., Gran		-	21536	,
e e	s 1 an if Heal item 2 other		20a. Method of Disposition		20b. Plac		sition (Name of natory or other place				tion - City or T	
Saltimor	Pages nent of int: if ite iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci.				-	ry Sept	3, 200	9 Gra	ntsvil	le, MD
art	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 is marke any injury or other traumatte. onee.		21. Signature of Funeral Service Lice	nsee	11.0.01	22	. Name and Addres	ss of Facility Nev	vman Fund	eral	Homes,	P.A.
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			23a. Part1. Enter the disease, or consolock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death
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Š	death ce le attend ed for use	Physician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p	2 🗌 Fetal d	eath 3	Ectopic pregnancy	1		230	I. Date of delive Month	very Day Year
5	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4⊡Pregnant at 9⊡Unknown	time of dea	th 5L	Other (specify)				West	Day Tou
ř.	that t		Part II. Other significant conditions	contributing to death bu	ıt not resulti	ing in the un	derlying cause give	en in Part I.	23e. Did tob	acco use	contribute to	the cause of death?
cords	The law requires that the death cer tte has been signed by the attendin bage 2 should be detached for use	d by	old CVA, di	abetes	Mi	nent	tuice	7	1 □ Ye	s 2 🗆 l	No 3 ☐ Pro	bably 4 Unknown
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5 6	ding Physician: h. After this certific funeral director,	은	1 ☐ Yes 2 10 No	Hospital: 1 ☐ Inpatier	nt 2□EF	R/Outpatient		4 Nursing Ho	me 5 Reside	nce 6	Other (Speci	ify)_
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	death death stor: , the f	icati	2 Accident investigation 3 Suicide 6 Could not b	e 290 Place of inju	nı - At home	o form otro		Yes 2 □ No	006 1 (04			10 11
<u> </u>	after after Direct	Certification:	4 Homicide determined	building, etc	(Specify)	e, iaiii, sire	et, lactory, office		City or Town	eet and N , State)	iumber or Hui	al Route Number,
	to the hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Certifier Certifying Pl	nysician: To the best o	of my knowle	edge, death	occurred at the tin	ne, date and place,	and due to the ca	use(s) an	d manner as	stated.
:	he Hc in 24 he Fu pletel	Medical	(Check only one) Medical Example (Check only one)	mlner: On the basis of and manner stat	examination	n and/or inv	estigation, in my o	pinion, death occur	red at the time, da	ate and pl	ace, and due	to the cause(s)
i	Nith To T	Σ	29b. Signature and title of certifier	1/	A	1	29c. License	e number	29	-	igned (Month,	Day, Year)
			Margaret	adam	. /	ND	D	46650)	8-	31-0	9
		3	30. Name and address of person who	completed cause of de	eath (Item 2	3a) (Type, F	Print)	morne	Do	A.	10	0 111
à .	Sta	te	31. Date filed Month, Day, Year)	32. Registra	r's Signatur	re /	too/ne	monne	PR	Ull	man	1110
	Registr		AUG 3 1 200		A	hour	de					21350

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06605 State of Maryland / Department of Health and Mental Hygiene Harold Asten Black, Jr. 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 23, 2009 1128 hrs Medical Examiner Harold Austin Black Jr. c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Garrett Oakland Garrett Co. Memorial Hospital 9. Birthplace (State or 8. Date of Birth (MM/DD/YYYY If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Foreign Country) VA **Funeral** Hours Min Months Days Director Nov 29, 1971 1X M 2 37 225-90-7478 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 X Yes 2 No 28a-f shov MD Garrett Mtn. Lake Park I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hvoiene Director 10g. Citizen of What Country 10f. Zip Code 23a or 28a-notified at c 10e. Street and Number 105 United States 110 A Street, Apt. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Mantal Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces: 1 X Never Married Married 2 X No Yes Specify: White If Yes, Give Year Yes 2X No specify: Widowed Divorced ò 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than " Baltimore, MD 21215-0036 Lawn & Maintenance Laborer 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Erma Garrett is marked event, Be Harold Austin Black Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) c/o 55 Sunset Vista, Frostburg, MD Erma Black, Mother If item 27 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Horseshoe Run, WV 08/27/2009 Donation 5 Other Specify: Accident Cemetrey 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A.
21 N. Socond St., Oakland, MD 21550 21. Signature of Funeral Service Licensee N. Second St., Oakland, MD otherine 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Death /Medical a. Pulmonary Thromboembolism Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) b. Deep Venous Thrombosis of the Left Leg Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit g **AMENDED** UNPENDED Physician/Medi Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✔ No 3 Probably 4 Unknown چ Completed has been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✔ Yes 2 1 🗸 Yes 2 No certificate funeral director, page 26 Place of Death (Check only one 25. Was case referred to medical Be Other₄ Hospital: 1 examiner? Residence 6 Nursing Home 5 Inpatient 2 V ER/Outpatient 3 DOA this 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey,Yeer) 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death 1 V. Natural Yes 2 Pending death. Funeral Director: stely filled in by the Certificati 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 24 hours after 3 Could not be or Town, State) Suicide determined (Specify) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 24, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD 31. Date filed (Month, Part 25) 32 Registrar's Signature State mari Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06343 State of Maryland / Department of Health and Mental Hygiene Francis Connolly Certificate of Death 1- For State Reg. No Registrar Time of Deat 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 13, 2009 1410 hrs Francis H. Connolly **Medical Examiner** 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Salisbury 107 Overlook Drive 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 6. Sex Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Days Hours Min Months Couldlinois 10/18/1947 Director 358-38-2146 61 1 X_M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No Wicomico Salisbury Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 107 Overlook Drive 21804 USA or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Never Married 2 X Married 2 X No Yes white Yes 2 X No specify: Specify If Yes. Give Year Divorced If item 27 is marked other than "natural", 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) or other traumatic event, the Medical Baltimore, MD 21215-0036 4 12 tax director corporate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Connolly Mary Ducey Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donna Connolly/spouse 3901 Meadow Bridge Rd., Salisbury, MD 21804 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) X Burial 2 Cremation 3 Removal from State Wicomico Memorial 8/18/09 Salisbury, MD Important: Donation 5 Other Specify Park Name and Address of Facility Holloway Funeral H 501 Snow Hill Rd., 21. Signature of Funeral Service Licensee Home Professional Association FI 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Between Onset and failure. List only one cause on ea Death /Medical a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **xamine** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED icate has been signed by the attending physician page 2 should be detached for use as the burial Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy Year Month Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Yes 2 No 3 ✔ Probably 4 Unknown ģ Chronic Obstractive Pulmonary Disease Completed 24b. Were autopsy findings available 24a. Was an certificate has been autopsy prior to completion of cause of death? performed? ✓ Yes 2 1 🗸 26.Place of Death (Check only one To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, 1 25. Was case referred to medica Division of Vital Be examiner? Other; Nursing Home 5 Residence 6 VOther: Scene Hospital: 2 ER/Outpatient 3 Inpatient 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 Pending 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

81

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

AUG

19

Ling Li, MD

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Sign

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

State

Registra

29d. Date signed (Month, Day, Year)

August 14, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 257pm Month Vear **Physician** annow 0 a /Medical County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Year) Days Months Hours Yrs. 63 1-17-1946 MD Director 215-44-6384 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or Items 25a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified in once. 1 XYes 2 No Director Salisbury Wicomico MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. 21704 U.S.A. 30406 Cannon Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. No Naval If Yes, Give Year or Dates: 1969 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No þ Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Clerk **\$tandard Register** 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Etta P. Raynor 2 Hammond G. Cannon, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30406 Cannon Drive, Salisbury, MD 21804 Jaunesta Cannon/Wife Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Springhill Garden 8-22-2009 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bennie Smith 917 W. Isabella St.
Funeral Home Salisbury, MD 21801
List only one cause in each line. 21. Signature Jan Tra Service 23a. Part 1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Physician 91 /Medical to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant ned by the atter detached for u 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 2 No 9 Unknown 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 MNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 21 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i Certification: To 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Em Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie f person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Salisbury MD 21801 Jethey Wieland 100 E. (arroll Registrar's Signature 31. Date filed (Month, Day, Year) State 0 1 Registrar AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 10:05 AMM White Carey Pauline 14 2009 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico Salisbury Wicomico Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Maryland 1 □ M 2 🕱 F 06/25/1917 231-20-6350 92 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director Salisbury Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21.801 USA 500 Dogwood Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: white þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) health care 12 nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella L. Dvkes Martin B. White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Elizabeth St., Salisbury, MD 21801 Roger Carey/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 □Removal from State 8/18/09 Parsons Cemetery Salisbury, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kett K 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EREBROVASCULAR /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, learning to intra-eviate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐Yes 2 ☑ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To 1 | Inpatient After this 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SU .5 Mahesha Thimmarayappa M.D. 614 Easternshore Dr Salisbury MD 21804

State Registrar 31. Date filed (Month, Day, Year)

AUG 19 2009

DHMH 17 Rev 1/2001

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** August 23, 2009 1:15 a Robert Carter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1290 Hallowing Point Road Prince Frederick Calvert 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 ☐ F Director March 20, 1938 DC 215-38-2623 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 No Directo Prince Frederick MD Calvert 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country ŏ 23a 1290 Hallowing Point Road 20678 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MINO 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ò If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Black 'naturai" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Laborer and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Robert Louis Carter Helen Louise Royster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra once. P.O. Box 2264, Prince Frederick, MD 20678 Joan I. Carter - wife 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 Cremation 3 Kemoval from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory | August 25, 2009 | Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. Blades Sewell 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician NUSTUR disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical the IF FFMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Tyes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 200 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 □Yes 2 No 21 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 55 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation within 24 hours after con-To the Funeral Director: Aft 1 ☐ Yes 2 No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3 KW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan owent hal DUNKIRK. MD 10845 TOUN CTE BLYD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 25 2009 Jak Registrar

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		For State Registrar	State of N	/larylan		artment of H		and Mental H	ygiene	009	281	119
		Decedent's Name (First, Middle, L.)	.ast)					2. Date of Month	Death	Year	3. Time of	Death
Physicia /Medic		GLORIA S. (CLOUDEN					August	23. 2	009	9:57A.	M
Examin		4a. Facility Name (If not institution, g	ive street and numbe	er)		4b. City, Town, or	Location of			ounty of Dea	ath	
		Memorial Hospita	1			Cumbe	rland	24 Hrs. La Data et	Alle	egany	rthplace (State o	- Famille
Funeral		5. Social Security Number 6. 579–56–3136	Sex 7. A 1 □ M 2 1 F		ast birthday) Yrs,	Months Days	If Under	Min. 8. Date of (Month, 01/05)	Day, Year)	C	rtinpiace (State o Country) INGLAND	r roreign
Director		Usual Residence of Decedent		70				01/05/	1939	E	INCTIVID	
yland		10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside Cit	
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item item inerr	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces 1 □ Yes 2 0	s?	5. 13.	If Yes, specify Cuba	an, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)	NO- 14.			
urs af	þ	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates			1 □ Yes 2 XX No	Specify:		Sp	Specify: WHITE		
72 ho	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usual Occup	ation	t of workina	16b. Kind	of Business	s/Industry	
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shoul ind M i marl	<u> </u>	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rural Route Nui	nber, City or T	own, State,	Zip Code)	
and 2 ralth a 127 is er tra		RUSSELL CLOUDEN	/ SON		18504	4 PALMER	LANE,	RAWLINGS	, MD 2	21557		
of He fitem		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	Demoval from Stat	20b. P	lace of Dispo emetery, crer	sition (Name of matory or other place	e)	Date	20c. Loca	tion - City o	r Town, State	
Pag Iment tant: I		4 □ Donation 5 □ Other (Spe	cify)	CUN				8/26/2009	Ct	JMBERL	AND, MD	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the thereal Examinar must be notified at once.		21. Signature of Funeral Service Lic	ensee	111	22	2. Name and Addres UPCHURCH	FUNE	RAL HOME,	P.A.			
402 % 0		23a. Part 1. Enter the disease, or co	mpliadions that saus	and the death	Do not ont			REET, CUM), MD	21502 Approximate	e
		shock, or heart fallure. List on Immediate Cause (Final			1. Do not em	ter the mode of dyn	ng, such as	A A	y arrest,		Interval Bet Onset and I	ween
Physician /Medical		disease or condition resulting in death)	a. Que to (or :	as a consequ	Conce off:	eghat	opa	they			mine	Les .
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D +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	uence of):			1 0		-X,	you	~
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cate be executed bhysician and the burial-transit		resulting in death) cast	Due to (or a	as a consequ	uence of):							
physi physi s the b	dical		d									
leath certifica attending ph I for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon						230	d. Date of d	elivery	
death e atte d for	icia	in the past 12 months? 1 □ Yes 2 No	1 Live birth	t at time of d		☐ Ectopic pregnanc ☐ Other (spec <i>ify</i>)	У		-	Month	Day	Year
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) CertifyIng Medical Ex	Physician: To the be aminer: On the basis and manner	s of examina	ition and/or ir	n occurred at the the	opinion, dea	ath occurred at the tir	ne, date and p	lace, and di	ue to the cause(s	;)
To the within To the comp	Me	29b. Signature and title of certifier	0	_	<-	29c. Licens	e number		29d. Date	signed (Mo	nth, Day, Year)	
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2011		30, Name and address of person wh	no completed cause o	of death (Iten	23a) (Type,		10	Va P		-		151-
NdA Sta	te.	31. Date filed (Month, Day, Year)	1 2. Regi	strar's Signa	ture	yemor i	d VY	Ve., Cur	UKI 10	110,1	11)) S/	30_
Registr		AUG 26 20	09 Sentes	w \$.	par	Med .						

Registrar
DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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		For State	State of Mary		irtment of Hea tificate of De			9	1110	28721
		Registrar 1. Decedent's Name (First, Middle, Last)		007	O * 1	airi	2. Date of Death	g. No.	3 0 0	3. Time of Death
Physici		Darwin Ed	mundo	Ramos	Cerriti	SC	August	22	2001	17:35 M
/Medic Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or Loc		· ·	4c. Count	y of Death	
		The Johns Hopkins Ho 5. Social Security Number 6. Sex		In yrs. last birthday)	Baltimore C	Under 24 Hrs.	8. Date of Birth		9. Birthpl	ace (State or Foreign
Funeral Director			M 2 □ F 23			lours Min.	sept 5	1985	Countr	emala
70		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Los	ration				10	0d. Inside City Limits
//anylar f shov ed at	ō,	Maryland Harford	'	Edgewood	Janon					Yes 2 No
r 28a- notifie	Direct	10e. Street and Number		Lagewood	10f. Zip-Code		10	g. Citizen of	What Count	ry?
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er dea items er mu	Funeral	11. Marital Status 1X Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2X No	er in U.S. 13. \	Vas Decedent of Hispa f Yes, specify Cuban, N	anic Origin? (Spe Mexican, Puerto I	ecify Yes or No- Rican, etc.)		ce - America ack, White, e	
urs affe	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	¥ Yes 2 No S	ipecify: Guater	malan	Spec	ify: W	hite
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yiand < 1 < purple of the filed with Mental Hygiene. arked other than attic event, the Mental Hygiene.	To Be	Hector Edmundo R	Ramos			Rosa Is	sabel Ce	rritos	3	·
Taryla 2 should and Ment is market aumatic e		19a. Informant's Name/Relationship (Ty	pe. Print)		ng Address (Street and					Code)
≥ ¬ ∈ > ≥		Hector Edmundo Ra 20a. Method of Disposition	mos (Fathe	er) 804 F	isherman L		gewood,)40 ı - City or Tov	wn State
baltimore, in permit. Pages 1 am Department of Healt Important; If item 2 any injury or other once.		M Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, crer.	natory or other place) io General	08/29				Guatemala
Daltimo Dermit. Pages Department of mportant; If it any injury or price.		21. Signature of Funeral Service License			Name and Address of					
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Physician / Medical		Immediate Cause (Final disease or condition resulting in death)	a	onseopath	rc Hemo	lutic	Anem 1	۸		
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Attending ar death. ector: After by the func	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Y	'ea <i>r)</i> Injury		3 2 □ No				
or Atte frer de frecto in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	/ - At home, farm, str <i>(Sp</i> ec <i>ity)</i>	eet, factory, office		28f. Location (St City or Town		mber or Rura	al Route Number,
pital ours a eral D		29a. Certifier 1 CertifyIng Phy	rsician: To the best of r	my knowledge, deat	n occurred at the time,	date and place,	and due to the c	ause(s) and	manner as s	tated.
DIVISION OF VITAL HY To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(check only 2 Medical Exam	iner: On the basis of e and manner state	xamination and/or in ed	vestigation, in my opin	ion, death occur				
To the transfer of the transfe	Z	29b. Signature and title of certifier	-(29c. License nu	umber	\rightarrow \bigcolon \rightarrow \bigcolon \rightarrow \bigcolon	9d. Date sigi	ned (Month, I	Day, Year)
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St Regist	ate	31. Date filed (Month, Day, Year) AUG 2 5 2009	32. Registrar's	s Signature	,	600	North Wol	ie St, E	allimor	e, MD, 21287

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** ROGER FRANCIS CURTIS 18:40P M AUGUST 19 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 13 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1938 217-32-1067 71 Jan. Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exprairse must be rotified at Monrovia Md. Frederick 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 11795 Thomas Spring Road 21770 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No 1956-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1∐Yes 2⊠No þ Specify: 3 Widowed 4 Divorced 1962 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Excavation 12 Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Agatha Walker Aubrey Alton Curtis Tnez ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11795 Thomas Spring Road, Monorovia, Md. 21770 Shirley J. Curtis / Wife other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition = 5 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Metropolitan Crem. 8/20/09 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee M-00 P. O. Box 5038, Laytonsville, Md. Approximate Interval Between Onset and Death 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acude **Physician** responden tuilur disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ventral hernih the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy this certificate 1 ☐ Yes 1 TYes 2 No Physician; 25. Was case referred to medical examiner? director æ 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After thi 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? or Attending Division 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death, within 24 hours after death To the Funeral Director: completely filled in by the f 6 ☐ Could not be 3. Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier KINNTIKD DO068658 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12+1 Kinnainl 20832 Olney, Md. 18101 Prince Philip Drive, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

AUG 2

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Month Cecil 24, Walter Henry 2009 1930 August /Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Garrett County Memorial Hospital 0akland Garrett If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 214-28-6311 Director 80 April 20 1929 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Operatment of Health and Mental Hyglene. The Carlot is it fiers 73 as marked other than "natural", or items 23a or 28a-f show Important: It fiers 7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exercites must be nothing as Director 1 ☐ Yes 2 XNo Garrett McHenry 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 110 Jrs Drive 21550 United States **Funeral** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No δ 3 Widowed 4 Divorced Year or Dates: WWII White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Homebuilder 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) 0scar Cecil Ada Robinette ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Offutt, Friend 827 Iron Rail Court, Woodbine, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Cumberland Crematory | 08/25/2009 Cumberland, MD Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 Katherin Sweets 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cuidiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician /Medical resulting in death) Due to (or as a consequence of) Examiner Thoro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) ☐Yes 2☐No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 22 No 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Dopatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Watural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death Director: A in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in 24 hours a 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D23979 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Goralski, MD 311 N. Fourth Street, Oakland, MD 21550 Robert A. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

P.O.

		•	For State Registrar	State of Mar		rtificate of I			giene 2 0	09	2872
	Physicia		Decedent's Name (First, Middle, La. Margar	et Louise C	avil			2. Date of Dea Month August	Day	Year) 9	3. Time of Death 10:45 p M
)	/Medic Examin	_	4a. Facility Name (If not institution, giv Collingswood Rehabilitat	e street and number)		4b. City, Town, or	Location of Dea		4c. County		
A	Funeral Director		5. Social Security Number 6. S	7. Age ((In yrs. last birthday)		If Under 24 Hrs Hours Min		th y, Year)	9. Birthpl Count	lace (State or Foreig
patinitions, inial yialio 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 21 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Ceci 10e. Street and Number 1006 Frenchtown 11. Marital Status 1 Never Married 3 Widowed 4 Divorced 15. Decedent's Error (Specify only highest grave) Elementary/Secondary (0-12) Twelve Years 17. Father's Name (First, Middle, Last, George R 19a. Informant's Name/Relationship (Rose Cavil 20a. Method of Disposition 1 Decedent Secondary (10-12) 1 Decedent's Error (10-12) 1	Road 12. Was Decedent Even Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Jucation adde completed) College (1-4or 5+) Campbell Type. Print) (daughter)	16a. Dece (Give life. Sup 19b. Maili 19610	Perry 10f. Zip Code 2 Was Decedent of H If Yes, specify Cuba I Yes X No Indent's Usual Occup Is kind of work done If Yes Poly Servi	Specify: ration during most of wo ice 18. Mother's Na and Number or R addle Dr	Specify Yes or No rio Rican, etc.) orking me (First, Middle, Mary El Bural Route Numbol ive, Gerr Date	14. Rac Blac Specify Aberdeer Aberdeer Maiden Surnan izabeth er, City or Town, man town,	What Counts S.A. e - America ck, White, e Y Whit usiness/Ind Prov n, Man Zimme State, Zip Mary City or To	an Indian, etc. te dustry ving Groun ryland erman Code) yland 208
,00,00	ate be executed Wedical Wedical Examiner In principle edical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	consequence of):	2. Name and Addre Lee A. Pa Per ter the mode of dyir	ng, such as cardia	ac or respiratory a	d 2190	3-076	Approximate Interval Between Onset and Death	
il necolds, r.O. box	w requires that the death certiful been signed by the attending should be detached for use a	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown Part II. Other significant conditions of	23c. If yes, outcome pf 1 Live birth 2 4 Pregnant at tir 9 Unknown		obacco use cont Yes 2 1 No an 24b. psy psy primed?	24b. Were autopsy findings availab y prior to completion of cause o death?				
DIVISION OF VILA	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To Be	25. Was case referred to medical examiner? 1	28a. Date of Injury (Month, Day)	/ - At home, farm, st (Specify) my knowledge, dea	of 28c. Injur Wor M 1 □ reet, factory, office	26. Place of Death (Check only one) 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? M 1 Yes 2 No				al Route Number, tated.
ı	To the H within 24 To the F. complete	Medical	29b. Signature and title of certification. 30. Name and address of person who	and manner state	~ O .	29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)

State Registrar SAYED E(SAYYAD LOllo Molebular Dr. Rockville, MD 20850 31. Date filed (Month, Day, Year) AUG 24 2009 Level D. Jane Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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ı	Physici		1. Decedent's Name <i>(First, Middle, La</i> Lloyd	Robert	Di	ehl		2. Date of Death Month	Day Year	3. Time of Death 1327 M	
*	/Medio Examir		4a. Facility Name (If not institution, given		Lmpus		Location of Death	00	4c. County of Deat	h	
	Funeral Director		Social Security Number 6. 8		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/06/1	9. Birt	hplace (State or Foreign untry) ennsylvania	
	Maryland a-f show	ctor	10a. State 10b. County	11egany	: City, Town or Loc	dman Mt.	Savage			10d. Inside City Limits 1.□□ es 2.□ No	
	h with the 23a or 28	Funeral Director	10e. Street and Number 15601 128 5th Avenue	Mile Lane, N	W	10f. Zip Code -155	21545 45	10	g. Citizen of What Co US A		
980	urs after deat al", or items (Exeminar mu		11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ፟፟፟ Divorced	12. Was Decedent Ever i Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	1951- "	Vas Decedent of Hi fYes, specify Cuba □Yes 2 X No	ispanic Origin? (Spi n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: White	e, etc.	
Maryland 21215-0036	d 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Modieal Exemirant must be notified at	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give I		ation Juring most of worki)	ng	6b. Kind of Business/		
nd 2		Be Co	17. Father's Name (First, Middle, Last			ssistant	18. Mother's Name		Tire and F	ubber.	
ıryla	2 should be f and Mental i Is marked of aumatic eve	70	Lloyd Wi	Illiam	Diehl	a Address (Street	Caroly		ry I City or Town, State, 2	Labin	
	5 ± 01 F		Brian W. Diehl /	Son	1560	1 Mile La	ane, NW,			545	
Baltimore,	STE		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control of the contro	nemoval nom State	Cumberlan		ory 08/27	/2009	oc. Location - City or Cumberland	, MD	
Ball	permit. Page Department of Important: If any Injury or once.		21. Signatule of Funeral Service Licer	dans					y Funeral rland, MD	Home, P.A. 21502	
	Physician /Medical		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the cone cause on each line. a. Due to (or as a con	EMIA	er the mode of dying	g, such as cardiac c	or respiratory arres	st,	Approximate Interval Between Onset and Death	
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. METHICL Due to (or as a con	LUN PI	5 S ISTA	NT STA	APH. E	PI	3 PAY S	
68760,	tificate be executed g physician and as the burial-transit	ledical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cond.	sequence of):						
. Box	death certi e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delivery Month Day Year						
	The law requires that the ate has been signed by the page 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but not	resulting in the un	derlying cause give	en in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown			
Division of Vital Records,		Completed						24a. Was an autopsy performe 1 ∐Yes 2 [prior to death?	topsy findings available completion of cause of	
of Viit		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	2 ☐ ER/Outpatient	3 □ DOA Othe	26. Place of Death r: 4 ☐ Nursing Hor		ce 6 ☐ Other (Spec	cify)	
ion	dling Fune fune	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year	28b. Time of Injury	28c. Injury Work M 1 □ Y	rat ? res 2 □ No	28d. Describe how	injury occurred		
Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	at home, farm, stre ecify)	et, factory, office	2	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,	
	To the Hospital or within 24 hours afte To the Funeral Diru completely filled in I	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	yslcian: To the best of my niner: On the basis of exan and manner stated.	knowledge, death nination and/or inv	occurred at the timestigation, in my or	ne, date and place, pinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)	
		Me	29b. Signature and title of certifier	0 1/		29c. License			I. Date signed (Month	i, Day, Year)	
	2+		30. Name and address of person who		Item 23a) (Type, P	rint)	14865		406, 2°	1,2009	
	N & A Stat		Robustiano B	arrera m.	D. 500	memoi	ial Ave	nue, Qu	mberlane	d.MD a 1502	
	Stat Registra		31. Date filed (Mark 2 8 200)	32. Registrar's Si	J. park						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certifica	te of L	Death	F	Reg. No.	0110	28725
	Dhusiai		1. Decedent's Name (First, M.	ddle, Last)						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		Charles W	illiam Emer	son					August 1	8, 2009		11:30 p M
7	Examin	er	4a. Facility Name (If not institu	ıtion, give street ar	nd number)		4b. Cit	y, Town, or	Location of Death			ounty of Death	1
كعمديد			1076 Claggett 5. Social Security Number	Road 6. Sex	17.00	e (In yrs. last birti		underla er 1 Year	and If Under 24 Hrs.	8 Date of Birth	h	Calvert	nplace (State or Foreign
ı	Funeral Director		219-16-2000 Usual Residence of Decedent	1 ★ M 2□			rs. Month		Hours Min.	8. Date of Birtl (Month, Day July 8, 1		Cou	intry)
	dand ow	Ì	10a. State 10b. Cou			10c. City, Town	or Location						10d. Inside City Limits
	Many a-fsh	żo	MD Ca	lvert		Sunder	derland			1 □ Yes 2 🔀			
	or 28	Director	10e. Street and Number				10f. 2	ip Code		10g. Citizen of What Country?			
	ath wi	ral	1076 Claggett					0689		USA			
	er de	Funeral	11. Marital Status	12. Was	Decedent led Forces? Yes 2	Ever in U.S.	13. Was Dec	edent of H ecify Cuba	ispanic Origin? (Sp in, Mexican, Puerto			I. Race - Amer Black, White	
36	rs aft	by F	1 ☐ Never Married 2 ☐ I 3 ☐ Widowed 4 ☐ Divor	If Ye	s, Give r or Dates:	40	1 □ Yes	2. No	Specify:			Specify:	Black
21215-0036	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show diest Evanime must be Lodified at	ted	15. Dece	dent's Education	atad)	16a.	Decedent's Us	sual Occup	ation	ring I	16b. Kind	d of Business/li	
2	thin 7	Completed	Elementary/Secondary (0-1	ghest grade comple 2) Colle	ege (1-4or 5	+)	life. DO NOT	ive kind of work done during most of workir e. DO NOT use retired)		ang	ng		
2	ed wi lygier her th	Co	4					Lab	orer	e (First Middle	Construction Maiden Surname)		
and	be fill	Be	17. Father's Name (First, Mid							,	ivialuen S	umamey	
Maryland	hould id Me mark	ပ္	Mason Emers 19a, Informant's Name/Relati		<i>t</i>)	19b	Mailing Addre	ss (Street	Priscilla C		er. City or	Town, State, Z	ip Code)
Ma	nd 2 sulth ar 27 is rtrau			, , , ,					innett Ave.				*
ē,	s 1 ar if Hea item 3		20a. Method of Disposition	Emerson -	•	20b. Place of	Disposition (A y, crematory o	lame of	milet Ave. 1	Date	20c. Loca	ation - City or	Town, State
Ë	Page nent o nt: If iry or		1Æ Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe		from State				etery August	24, 2009	Chesa	neake F	Beach MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experimental Laboration once.		21. Signature of Funeral Sen	1/	100	0	22. Name	and Addre		well Funera	al Home	e, P.A.	
			23a. Part 1. Enter the disease	e, or complications	that caused	the death. Do n						, IVID 200	Approximate Interval Between
-	Physician	F 17	shock, or heart failure. Immediate Cause (Final	List only one cause	e on each III	Sh	a ,)	leno	al Dise	esce			Onset and Death
	/Medical		Immediate Cause (Final disease or condition resulting in death) a. End Stag Rena Visease Due to (or as a consequence of): The The Dischets b. Sequentially list conditions.										
	Examiner												
	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ □	ue to (or as	consequence of	of):	1.					
_	and and II-tran	xarr	that initiated events resulting in death) Last	c	ue to (or as	a consequence of	of):						
68760,	e be e sician buria				,	·	•						
687	rtificate be executed ng physician and as the burial-transit	Medical		d									
Box		M/III	IF FEMALE: 23b. Was decedent pregnant			of pregnancy 2 Fetal death	3 ☐ Ectopi	c pregnanc	av.		23	3d. Date of del	
O. B	law requires that the death ce as been signed by the attendi 2 should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 🗆		t time of death	5 Other					Month	Day Year
Р.	d by t	Phy	9 Unknown Part II. Other significant con			ut not regulting in	the underlying	a cauco aiv	on in Part I	23e Did t	obacco us	e contribute to	the cause of death?
ds,	signe	ğ	A		y to death b		~ P N	7 ca	CITITITI OF C.	10		,	robably 4 Unknown
Ö	w requir	etec		1 and						24a. Was	an	24h Ware au	itopsy findings available
Rec	has las	Completed		talen	1570					autor	rmed?	prior to death?	completion of cause of
ā	ilcian: The lav certificate has rector, page 2		25. Was case referred to me	dical					26. Place of Dea	1 Tyes	2 No	1 □ Yes	2 No
Ē	/slcia	o Be	examiner? 1 ☐ Yes 2 ☐ ★o	Hospital	1 □ Innatio	ent 2 ☐ ER/Ou	toatient 3 □	DOA Oth	or:	ome 5 Resi		□Other (Spe	cify)
10	g Phy ter thi	Ë	27. Manner of Death		Date of Inju	ıry 28b. 1	Time of	28c. Injui Wor	·	28d. Describe			
jo	Attending in death. ector: After by the fune	atio	Z	estigation	(month), Do	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	М		Yes 2 □ No				
Division of Vital Records,	al or Atte s after de l Directo	Certification: To		termined 28e.		ury - At home, fa c. (Specify)	rm, street, fact	ory, office		28f. Location (City or To	Street and wn, State)	Number or Ru	ural Route Number,
	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Medical C	29a. Certifier 1 Certifier (Check only one) 2 Med	ifying Physician: ical Examiner: Or and	To the best the basis of manner st	of examination an	e, death occurr d/or investigat	ed at the ti	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	within To the	Me	29b. Signature and title of ce	rtifier	15	7		29c. Licens				signed (Mont	
			•	/h/				0	3312	3	6	8 20	09
	2W		30. Name and address of pe	- / .		death (Item 23a)	(Type, Print)			Prince	F.	lovick	09 MD 20678
	Sta	te.	31. Date filed (Month, Day,)			rar's Signature	1	1	I	111111		ici idi	, 1-17 = 0,0
	D!-A		AHC 9.1 2000	Chause	J D.	Lacres							

Amended #22, nls, per fd, 08/27/09, Allegany Co. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 22:19 **JANE** HILDA 25 EVANS gust 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegan WMHS- Memorial umber land Campus If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 💢 F 80 Director 220-26-9948 11/04/1928 WEST VIRGINIA Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No Director WV MINERAL KEYSER the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with ROUTE 1, BOX 192 26726 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, its the first Examina 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) RETAIL GROCERY STORE Elementary/Secondary (0-12) College (1-4or 5+) AND AUTO SALES CO-OWNER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN DAVID KIMBLE, SR. SAMANTHA SMITH ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEONARD EVANS / HUSBAND ROUTE 1, BOX 192, KEYSER, WV _26726 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FORT ASHBY CEMETERY 08/28/2009 FORT ASHBY, WV 22. Name and Address of Facility 21. Signature of Funeral Service Licen UPCHURCH FUNERAL HOE, INC. P.O. BOX 1260, FORT ASHBY, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** EARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2-☐ No the 9 Unknown 9 D Unknown ģ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 No 1 □Yes 2 ☑No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1. Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No s after death. death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 5 20 of person who completed cause of death (Item 23a) (Type, Print) nds Highway Lavale, MD Shiv Khanna 1221 E Nationa 31. Date filed (Month, Day, Year) AUG 27 2009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 09:45A M **Physician** Hilman Andrew Fooks /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** Wilcomica aKE Salsburg If Under 1 Year If Under 24 Hrs. at the Hospice Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 79 MD Director 8-18-1929 213-22-7919 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examirar must be indified at 1X Yes 2 □ No **Funeral Director** Salisbury MD Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 706 Shiloh Street 21804 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black ģ 3 □ Vidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Deer's Head Hospital 10 Attendant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Myrtle Boone 2 George Fooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any Injury or other trau Pages 1 and 2 706 Shiloh St, Salisbury, MD 21804 Fannie Johnson/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-22-2009 Mardela Springs, MD John Wesley Cem 8-21 Signature of Mneral Service Licensee 917 W. Isabella St Bennie Smith Salisbury, MD 21801 Funeral Home Salisbury tenter the mode of dying, such as cardiac or respiratory arre-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LZHBIMRA DISRASP **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine under cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of): burial-t Box 68760. physician pe Physician/Medical the attending p for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No P.O. the 9 Unknown as been signed by 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 3 Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform page 2/1 No 1 Yes 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 6 Bother (Specify) HOSPICIZ Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Mapper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0

Registrar

SAUSURY UND 21802

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOX

e HULAUN WAR

31. Date filed (Month,

AUG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last)

3. Time of Death

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Examinar must be notified at any injury or other traumatic event, The Medical Examinar must be notified at any once. **Physician** /Medical

Baltimore, Maryland 21215-0036

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O.

2. Date of Death Louise Cranford Finn 4:11 A M August 20, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 44564 Aspen Lane California St. Mary's If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Oct 4 1 □ M 2 🔀 F Months Days Hours 1919 89 216-30-2782 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State MD St. Mary's 1 ☐Yes 2X No Director California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 44564 Aspen Lane 20619 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married White 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) School Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mortimer Cranford Ethel Westcamp ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Finn-Bunales (daughter) 44564 Aspin Lane California, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem 4 ☐ Donation 5 ☐ Other (Specify) 2009 Cheltenham, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home Calvert, PA Day y. Golf 8125 Southern Maryland Blvd. Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respinatory Tract disease or condition resulting in death) Due to (or as a consequence of): SLASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify). 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bennidden 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 🙀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RM H. Bundy, M.O. D21893 30. Name and adress of person who completed cause of death (Item 23a) (Type, Print) 22335 Explanation Park Drive ROY H. BUNALES, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 20 ay August 2009 2:45 A **Physician** FREEMAN THEODORE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Silver Spring Bedford Court Assisted Living If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months Days Hours 1**™**M 2□ F 102 sept. 10 1906 Hungary 271-01-0288 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28e-f show 27 is marked other than "neturel", or flems 23a or 28e-f shov traumatic event, the Medical Examinat must be notified at 1 Yes 2 No Silver Spring Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20906 3701 International Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. ent: If item 27 Is marked other than "neturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Telegraph Union Officer 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Unknown Morris Freeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6715 Olney-Laytonsville Rd., Laytonsville, Md. 20882 Janet F. Stadler / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. 8/26/09 Rockville, Md. Parklawn Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furtheral Service Ceesse 22. Name and Address of Facility Muriel H. Barber Funeral Home 20882 Box 5038, Laytonsville, Md. m-00470 P. O. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MYOCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed use as the burial-tran attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year lor in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ②Unknown CHRONIC PANCREATIC INSUFFICIENCY page 2 should Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No DEBILITY certificate has 1 ☐ Yes 2 X No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Deatn (Check only one) director, Be Assisted Living Other: 4 Nursing Home 5 Residence 6 Stother (Specify) Hospital: c 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA are safter dea... 28b. Time of 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Mapner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗀 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a 😢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 20, 2009 D0035045

12

31. Date filed (Month, Day, Year) AUG 24 2009 State Registrar

Philip G. Henjum, M.D. 32. Registrar's Signature pake

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

18109 Prince Philip Dr., #200, Olney, Md.

20832

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2. Date of Death Day Year **Physician** 9:30 P.M August 23, 2009 William Fullerton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Center Frederick Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs, last birthdav) **Funeral** Months Days Hours Min. **™** M 2□ F 229-16-4317 86 Director March 9, 1923 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Eventment to maillind at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Tyes 2 No Funeral Director Maryland | Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24909 Ridge Road 20872 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1X□Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 🛣No Specify: à 3 Widowed 4 Divorced WWII White Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automobile Service Chrysler Dealership 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Rudd Fullerton Fannie (unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Fullerton - Wife 24909 Ridge Road, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematorium 8/25/09 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 21. Signature of Funeral Service Licenses 26401 Ridge Road, Damascus, Maryland 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) northe Carcinoma **Physician** /Medical Due to (or as a cons uence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sined hours and an action of the funeral Director. Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 2 ☑ No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 10 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) MA D26499 August 24, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2+1 Ronald E. Miller, M.D. 4 Culwell Drive, Mount Airy, Maryland 21771 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001 AUG 25 2009

Maryland 21215-0036

Baltimore,

P.0.

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 12:25 PM Sandra Lee Graybill 8 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Worcester Berlin Atlantic General Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9/22/1941 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 □ M 2 🕱 F 67 175-34-4936 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 200 1 ☐ Yes 2 ☑ No York York PA 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA 17406 5460 Mount Pisgah Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐Yes 2√2 No If Yes, Give Year or Dates: Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Austin W. Dietz Ruth Henry traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 5460 Mount Pisqah Rd., York, PA 17406 Robert W. Graybill / husband Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Locust Grove Cemetery 8/26/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-tran Due to (or as a consequence of) Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical the attending pl IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No signed by the Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has d in by the funeral director, page 2 s autopsy performe 2 **Z**-No 1 ☐ Yes 2 🗆 No 1 ☐Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours af

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 1 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 02-22-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHOW ST. SHOW HUL NO 21263 32. Registrar's Signature RA 10 31. Date filed (Month, Dav. Year) State AUG 2 5 2009 Registrar

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120150

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 2009 6:35 P M JOHN HENRY GOLDEN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MARCH 15 1940 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 1 ₩ 2 □ F Months Hours WASHINGTON, DC 69 Director 579-50-4863 Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinar must be notified at 1√ Yes 2 No Director WALDORF MD CHARLES 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20601 USA 5212 CAROLINE CIRCLE Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 No Airforce
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 ☐Yes 2 🖾 No Specify: ģ 3 ☐ Widowed 4 🕅 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH POSTAL CLERK GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any linkry or other traumatic en once. FRANCES **JOHNSON** JOHN GOLDEN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORNA K. DANIEL/DGT. 19 GARDEN HILL COURT DURHAM, NORTH CAROLINA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MARYLAND VETERANS CEME 8/31/09 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Lervice Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** ANOXIC ENECPHALOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASYSTOLE Sequentially list conditions, It any loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of death certificate be executed CORONARY ARTERY DISEASE attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, MITRAL VALVE DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate 2 😾 No Vital 1 ☐ Yes 2 📆 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F after death. Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 OLD GEORGETOWN ROAD BETHESDA, MARYLAND 20814 MELISSA MEANS M.D. 31. Date filed (Month, Day, Year) AUG 2 5 2009 32. Registra Signat State Registrar

book

09-06788 Dean Geiser Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ August 31, 2009 0513 hrs Taylor Geiser Dean Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Worcester 140 Ocean Parkway 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Mary Land Min. Months Days Hours Sep 27,1959 217-82-0977 Director 49 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No Berlin Worcester Marvland 10g. Citizen of What Country? Director 10f. Zip Code 21811 10e. Street and Number or items 23a or 28a-must be notified at U.S.A. 140 Ocean Parkway 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. tem 27 is marked other than "natural", or items traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 Never Married 2 X Married 2 X No Yes White Yes 2 X No specify: Give Year Widowed 4 Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If tiems 77 is marked other than "matura injury or other traumatic event, the Medical Examitingury or other traumatic event, the Medical Examitingury or other traumatic event, the Medical Examitingus or other traumatic event the Medical Examitingus or other examitingus or other traumatic event the Medical Examitingus or other traumatic event the Medical Examitingus or other examitingus or other traumatic event the Medical Examitingus or other exam 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ BoatMarina Manager 4 18 Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Carmack Nancy Lou Geiser Be Norman Spencer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 140 Ocean Parkway, Berlin, Maryland 21811 Mrs. Donna Geiser, Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place)
Smithsburg Crematory Burial 2 X Cremation 3 Removal from Stat Sep 2,2009 Smithsburg, Maryland Donation 5 Other Specify Funeral Service Agensee

22 Name and Address of Facility
Keeney & Basford P.A. Funeral Home
M00706 106 East Church St, Frederick, Mary
the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart nature of Funeral Service Agenses 21. Si Marvland 21701 Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. a Contact gunshot wound of head Death √Medical Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Couse (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical 23a,27,28a-f,perm,E g900 2/5/10 TT X UNPENDED AMENDED Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Day Year 3b. Was decedent pregnant in the 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✔ No 3 Probably 4 Unknown à Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' 1 🗸 Yes 2 No ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Hospital: Other_z Nursing Home 5 Residence 6 V Other: Scene DOA ER/Outpatient 3 Inpatient ٩ 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: subject shot self Natural Yes 2X No Pending Fd 0500 hrs Fd 8/31/09 28f. Location (Street and Number or Rural Route Number, City or Town, State) 140 Ocean pkwy. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1.
Berlin, MD 3 X Suicide Could not be determined (Specify) residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 1, 2009 O.C.M.E. wes 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Zabiullah Ali, M.D. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Dashields Hastings Oran August 20, 2009 12:45 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico 533 Priscilla St. Salisbury If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/21/1948 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 ☑ M 2 □ F Yrs 60 Maryland Director 218-50-1738 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Its Marical Examinar must be recitived at 1 X Yes 2 □ No Director Wicomico Salisbury Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or on the properties of the 533 Priscilla St. 21804 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 hotel security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Etta Davis ဂ္ Carl Hastings 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 533 Priscilla St., Salisbury, MD 21804 Etta Lejeune/mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts 8/20/09 4K Donation 5 ☐ Other (Specify) Hanover, MD Registry Phorieval Home Professional Association 21. Signature of Funeral Service Licensee 501 Snow Hill Rd., Salisbury, MD 21804 Compron 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METAS disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year P.O. 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2/1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending Injury death. 1 ☐Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Description Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifie

Name and address of

filed (Mo.

Year Day,

DHMH 17 Rev 1/2001

ORIGINAL

and manner stated.

o completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death August 22, 2009 **Physician** Hahn 5:15 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 12202 Auburn Road Frederick Thurmont 8. Date of Birth (Month, Day, Year)
May 26,1939 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min 1 □ M 2 🖾 F 219-36-3486 70 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Frederick Thurmont 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 7025 Kelly's Store Road 21788 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chistian Hauver, Sr. Bertha Raymond Lowery 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important; if Item 27 is any injury or other trau Brenda L. Hahn/Daughter 12202 Auburn Road Thurmont, MD 21788 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/26/2009 Blue Ridge Cemetery Thurmont, MD 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service 22. Name and Address of Facility Stauffer Funeral Home, PA 104 E. Main Street, Thurmont, MD 21788 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** dvanceo 1048 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to for as a consequence off Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 cate has been si 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 □Yes 2 □No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) daughter's Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(\triangle \) ASOther (Specify 1 Yes 2 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral home 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

completely filled in by the

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Drive, Suite Thomas 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Kanan

Fredene

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** John Robert Hetz /Medical City, Town, or Location of Death 4c. County of Death acility Name (If not institution, give street and number) Examiner BECAN CHOOCE VICEON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Y 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Social Security Number , Year) 1931 **Funeral** Months Hours Days Mary Land 1**X** M 2□ F 220-28-9935 Director Usual Residence of Decedent 10d. Inside City Limits 10c City Town or Location 10a. State 10b. County show ir than "natural", or items 23a or 28a-f show 1X Yes 2 No Director Frostburg MD Allegany 10f Zin Code 10g, Citizen of What Country? 10e. Street and Numbe 21532 81 E. Mechanic St., Apt. 204 USA death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 126/es 2 100 No If Yes, Give Korean Year or Dates: War 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or ite ury or other traumatic event, its Medical Examination. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify Specify: White 3 Widowed 4 XDivorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Farming 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Hetz Nancy Garlitz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2042 Iris Ave., Cumberland, MD 21502 Nancy Keister/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 31, 2009 Frostburg, MD Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD 20maaca 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or frear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final my ocated **Physician** Lonn acit disease or condition resulting in death) /Medical Due to (or as a consequatice of): Examiner hume Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy performed? 1 ☐ Yes 2 ☑ No Veglocement 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 tnpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation after death. I Director: Aid in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

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31. Date filed (Month, Day, Year) AUG

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Broadu 32. Registrar's Signature

021244

2009

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Houdersheldt Aug 29, 2009 2205 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Allegany Co. Nursing & Rehab Ctr. Cumberland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Dec 3, 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ XF Yrs. 216-22-5049 88 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County I Hygiene. other than "naturel", or ltems 23a or 28e-f show vent, the Medical Examinar must be notified at MD Allegany Cumberland 1 XYes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 730 Furnace Street 21502 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 is marked other than "naturel", or Ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white þ 3 Midowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home other traumetic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alfred W. Ridgeley Olive Abe Ridgeley ပ္ b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 426 Goethe Street Cumberland MD 2 19a. Informant's Name/Relationship (Type, Print) Olive Day daughter Cumberland MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Gremation 3 ☐ Removal from State ō 9/1/2009 Abe Cemetery WV Short Gap * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home, PA 21. Signature of Funeral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hear feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENDSTAGE CHRONIC OBSTRUCTIVE LUNG 8 44 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) by the a 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b autopsy perform certificate 1 ☐ Yes 2 ☐ No 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certlfication: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours are
To the Funerel Dir Fo the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who pleted cause of death (Item a) (Type, Print) MEDICAL BLOG. CUMBERUAND MD 21502 POBUSTIANO BARRERA Memorin M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parket **SEP 09** Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 **Physician** Johnson-3:00M avannah Nevaeh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** mnapolis Medical Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) ce (State or Foreign Funeral 1 □ M 2 X F Months Year) Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Medical Examinations to excite traumatic event. 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland thne Jomerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA 21853 Sland Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ oua ohnson 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 29936 Deal Island Road Princess Anne 45 21853 Informant's Name/Relationship (Type. Print) mother Lenise 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Alisbury, MID 4 Donation 5 Dother (Specify) Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complicating that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one consequences are not seen each line. Immediate Cause (Final **Physician** severe MOUR disease or condition resulting in death) /Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) been signed by the should be detached f 1 ☐ Yes 2 🕱 No 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? certificate Be Medical Certification: To death.

P.O. Box 68760. Records, Division of Vital filled in by the funeral director, within 24 hours after death To the Funeral Director: completely filled in by the To the Hospital

			1 ☐ Yes 2 🔼 No 1 ☐ Yes 2 🔼 No							
25. Was case referred to medical examiner?		26. Place of Death (Check only one)								
1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3	lospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
27. Manner of Death 1 X Natural 2 ☐ Accident 2 Natural 3 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	3d. Describe how injury occurred							
3 Suicide 6 Could not to determined		ctory, office 28	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one)										
29h Signature and little of entifier		29c. License number	29d. Date signed (Month. Day, Year)							

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Annapolis

Anne Arundel Medical Center 2001 Medical Parkway, An

State Registrar 30. Name and address

31. Date filed (Month, Day, AUG 2

DHMH 17 Rev 1/200

no completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 8 **Physician** 13:00M ockman /Medical nna 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arunde Annapolis If Under 1 Year | T Under 24 Hrs. Medical enter Birthplace (State or Foreign Country), Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Year) 1 □ M 2 🔀 F Days Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ral", or items 23a or 28a-f shore Examiner must be notified at 1 Yes 2 □ No Director Maryland omerse Mne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 anti of Health and Mental Hygiene.
anti If Item 27 is marked other than "natural", or items 23a or 1 and 17 and Island Road 29936 21853 USA Deal Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17_Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be lockman, Margie Denise Johnson Douglas ဂ wayne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29936 Deal Island Road Princes's Anne MD 19a. Informant's ame/Relationship (Type. Print) 29936 Deal Island Road Margie Denise Johnson mother permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/22/2009 Salisbury, 4 Donation 5 Other (Specify) 21. S gnature of Funeral Service Licenses 2180 WILL MEMOTVAL CHAPEL Approxi ate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** hour disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physiclan: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Year Day 5 Other (specify) 1 □Yes 2 X No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 2 00 2 **M**No 1 ☐Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Medical Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check only one)

30. Name and address

31. Date filed (Month, Day, Year)

as

AUG 2

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29b. Signature

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and manner stated.

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

H0053769

son who completed cause of death (Item 23a) (Type, Brint) note I Medical Center Anne Arundel Medical Center Sper, D. O. 2001 Medical Parkway, Annapolis, MD 21401

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8 **Physician** 09 tanley ichae 0740 a /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Alleganu numberland Braddock Campus If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Numbe 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1**X** M 2□ F 217-42-6445 MARCH 6,1946 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Marieal Examiner must be notified at Bedford Hyndman 1 XYes 2 No Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Clarence Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status be filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ò 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ontracto Construction ic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patricia Evelyn Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 Stringtown Rd Hyndman Jefferys DGH Department of Health a Important: If Item 27 Is any injury or other trainonce. Katie M, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 E Removal from State HYNDMAN HYNOMAN CEM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Harvey H. Zeigler F.H. Inc 169 Clarence St 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Lung **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Intracranial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b autopsy performed 1 ☐ Yes 2 🗷 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only

Registrar

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State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHEEMA

the

900 SETON DR

32. Registrar's Signature

29c. License number

CUMBERLAD

29d. Date signed (Month, Day, Year)

Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ruth H. 2009 Johnson 20, 6:40 P M August /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Thurmont 6536 Fish Hatchery Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 86 217-18-8415 May 26, 1923 Maryland Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Frederick Thurmont 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21788 6536 Fish Hatchery Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? 1944-1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Yes, Give Specify: 1946 ģ 3 ▼ Widowed 4 Divorced Year or Dates: 'natural' Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Pearson Rice Lillie Hahn 7 is marker traumatic ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health ar Health a tem 27 is Debbie Tavernie / Daughter 6529 Fish Hatchery Rd., Thurmont, MD 21788 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/25/2009 Frederick, Maryland Resthaven Memorial Stauffer Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final End Stage Melanoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Yrs Hypertension Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner July to for as a consequence off. Physician: The law requires that the death certificate be executed Yrs Exami Diabetes Type 2 and burial-tra Due to (or as a consequence of) Box 68760. Physician/Medical Dysphagia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖺 No Month Vear Day 5 Other (specify) P.O. 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Aneroxia, Gastritis, Neuropathy Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 XNo 2 XNo 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending after death. investigation 1 ☐Yes 2 ☐No 2 Accident 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide vo the Huswithin 24 hours are the Funeral D' 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 21, 2009 D54749 30. Name and address of person who completed cause of geath (Item 23a) (Type, Print) 0

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State

Registrar

Allen Reilly, MD

AUG 2 5 2009

31. Date filed (Month, Day, Year)

801

Registrar's Signature

Tollhouse Ave., Frederick, MD 21702

			For State State Registrar	•	epartment of Health and N Certificate of Death	Mental Hygien Reg. N	211119	28742
		Ħ-	Decedent's Name (First, Middle, Last)			2. Date of Death	New Year	3. Time of Death
	Physici /Medic		Jennie Love J	ohnson			1, 2009	3:15 a™
ng.	Examin		4a. Facility Name (If not institution, give street an	d number)	4b. City, Town, or Location of Death	4	c. County of Death	
			48 Canvasback Lane		Charlestown	_	Cee	cil
	Funeral	1	5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth Cou	place (State or Foreign ntry)
	Director		223-30-0523 1 ¹ M 2 X	1F 86 Y	rs.	June 20,	1923 V	irginia
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
	Aarylan f show ed at	5	Maryland Cecil		Charlestown			1 ¥ Yes 2 No
	the N 28a-	ec t	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Cou	ntry?
	with with the	Ö	48 Canvasback Lane		21914		U.S.A	•
	ms 2.	Funeral Director	11. Marital Status 12. Was	Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ameri	
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Ž	hould Me mark	은	19a. Informant's Name/Relationship (Type. Prin.) 19h	Mailing Address (Street and Number or Ru			n Code)
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ē,	s 1 and 2 f Health item 27 i		20a. Method of Disposition	20b. Place of I	Disposition (Name of		Location - City or T	
9	Page: ent o ht: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State New Br	ridge Baptist 08/ ch Cemetery 08/	'24/09 Col	ora, Mary	land
Baltimore,	parmit. Pages 1 and 3 Department of Health Important: if item 27 any Injury or other tr		21. Signature of Funeral Service Licenses		22. Name and Address of Facility Lee A. Patterson &			
m	parmi Depar Impor any Ir		Shomas M. tottl	thon, or	Perryville Mar	vland 2190		
4			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do no	ot enter the mode of dying, such as cardiac	or respiratory arrest,	, ,,,,	Approximate interval Between
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7	/Medical Examiner		resulting in death)	e to (or as a consequence of	r):			
5"	Examiner	_	Sequentially list conditions, b		n			
1	sit ed	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	e to (or as a consequence of	ny:			
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Division or Vital	spital or Attending Physician nours after death. neral Director: After this certifi filled in by the funeral director	Certification: To Be	examiner? 1	Date of Injury (Month, Day Year) Place of injury - At home, farr building, etc. (Specify) To the best of my knowledge,	patient 3 DOA Other: 4 Nursing Home of jury M 28c. Injury at Work? 1 Yes 2 No m, street, factory, office death occurred at the time, date and place	ome 5 Residence 28d. Describe how in 28f. Location (Street City or Town, St	and Number or Ruate)	ral Route Number,
Division or Vital	ne Hospital or Attending Physician n 24 hours after death. ne Funeral Director: After this certifi pletely illed in by the funeral director	Certification: To Be	examiner? 1 Yes 2 No Hospital: 27. Manger of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. 29a. Certifier (Check only 2 Medical Examiner: On	Date of Injury (Month, Day Year) Place of injury - At home, fart building, etc. (Specify) To the best of my knowledge, the basis of examination and	patient 3 DOA Other: 4 Nursing H me of jury Mork? M 28c. Injury at Work? 1 Yes 2 No m, street, factory, office death occurred at the time, date and place for investigation, in my opinion, death occurrence.	ome 5 Aesidence 28d. Describe how in 28f. Location (Street City or Town, St	and Number or Ruate) e(s) and manner as and place, and due	ral Route Number,
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Division or Vital	To the Hospital or Attending Physician within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director of the funeral director.	Medical Certification: To Be	examiner? 1	Date of Injury (Month, Day Year) Place of injury - At home, fart building, etc. (Specify) To the best of my knowledge, the basis of examination and	patient 3 DOA Other: 4 Nursing H me of jury Mork? M 28c. Injury at Work? 1 Yes 2 No m, street, factory, office death occurred at the time, date and place for investigation, in my opinion, death occurrence.	ome 5 Aesidence 28d. Describe how in 28f. Location (Street City or Town, St	and Number or Ruate) e(s) and manner as and place, and due	ral Route Number, stated. to the cause(s)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** (Ell Am 4.010 AROLINE /Medical County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, . Age (In yrs. If Under 1 Year **Funeral** Months Days Hours Min 1 ☐ M 2 7 F 82 213-22-8199 -2-1927 PRINIA Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location ortant; if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND Wicomico 10g. Citizen of What Country? 10e. Street and Number USA 900 Mohawk ZIBDI Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: BIACK Specify: þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic NONE 06 th and Mental Hygier 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 1 SAMES URION 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 900 MARGARE , Md DISCI mportant; If item 27 <= | AM Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Salisbury Crematerry Salisbury, Day 8-22-09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of F 21. Signature of Funeral Service Lice Sec any SAlis. Stewar tuneral Home leve 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ongestive disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Tonn ENSIDI Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of) Examiner be executed burial-transi and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as. attending IF FEMALE: use 8 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown P.O. 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 1 ☐ Yes over chiles Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐ Yes 1 Inpatient 2 R/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours within 24 hours a TEX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Datę signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO 30. Name and address of personumo completed cause of death (Item 23a) (Type, Print) (HOWA) 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 19

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-06490 State of Maryland / Department of Health and Mental Hygiene William Alphonsus Kenny 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ August 19, Day 2009 2134 hrs William Alphonsus Kenney, Jr. Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Allegany Frostburg 4013 Gottage Lane 10103 Cottage Lane, NW 9. Birthplace (State or Foreign Mary Land If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Min Months Days Hours 03/12/1967 218-80-1516 Country) Director 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 Yes 2 X No Frostburg Allegany s 23a or 28a-f show : e notified at once. MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21532 10103 Cottage Lane, N.W. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status Imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death will nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items; an other traumaite event, the Medical Examiner must be. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 X No Yes white Specify: If Yes, Give Year Yes 2 X No specify: Widowed Divorced à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) inspector rail 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Geraldine Cavanaugh Be William A. Kenney, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Geraldine Schurg 10103 Cottage Lane, NW, Frostburg, MD 21532 mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 08=24-09 Burial 2 XCremation 3 Removal from State Cumberland, MD Cumberland Crematory Donation 5 Other Specify: 22. Name and Address of Facility Durst Funeral Home 21. Signature of Funeral Service Licens 57 Frost Ave. Frostburg, MD 21532 co-lu Approximate Interval 23a, 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death /Medical a. Gunshot Wound of Head Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit The law requires that the death certificate be executed Physician/Medical attending physician a AMENDED UNPENDED 23d. Date of delivery Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 V No 3 Probably 4 چ Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? 2 No No ✓ Yes 2 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death. Division of Vital Be Other₄ Hospital: Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 1 Yes After this 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject shot self Aug 19, 2009 2111 hrs Natural 1 Yes 2 ✔ No Director: Pending 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number of Bural Route Number City or Town, State)

1973 Cottage Lane, Frostburg, MDFrostburg, MD 3 V Suicide Could not be within 24 hours a To the Funeral I determined (Specify) Single Family Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certil 2 August 20, 2009 O.C.M.E. - cle ekk 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Victor Weedn MD JD Assistant Medical Examiner nis 31. Date filed AUG, 25 2009 32. Registrar's Signature State Registrar

Amend #s 4a, 28f; nls, 08/25/09, per phy., Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death Month **Physician** August 10 2009 G. LINDEMON MONTELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerse rincess Manokun Manor 5. Social Security Number 7. Age (In yrs, last birthday) Date of Birth (Month_Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. PARYLANT 1 XM 2 □ F 215-12-9492 Director 89 Usual Residence of Decedent 10a. State 10d. Inside City Limits show 10b. County 10c. City, Town or Location 7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, treathedles Leamings must be routhed at Director 1 ☐ Yes 2 ☐ No MD NANTICOKE WICOMICO 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21840 Funeral 20185 NANTIWKE RD USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑₩0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE 1 ☐Yes 2 ☐No Specify: à 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Super VISOR Contenimal CAN CO maupheturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Health and Mental ပ SAMES LINDEMON AUGUSTA BAYNE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is any injury or other trauonce. PO BOX 191 NANTICOKE, MD SEANETTE AFBORAST Daughter 21840 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-15-2009 Turners ceineters MANTICOKE, MD 21. Signature of Funeral Service Licensee Conferen Jesuil & MESSICK FUNERAL HOME POBOXE! BYALVE, MD 21814 M00416 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 45CVD disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and burial-trar Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant lor 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the detached 9 Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 2 No certificate completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ⊡No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Mannet of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of After 1 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, Hospital or Attending death. after death e Funeral

with

death

filed within 72 hours after

Maryland 21215-0036

Baltimore,

the within To the 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29a. Certifier

(Check only one)

AUG 19 31. Date filed (Month State 2009 Registrar

29b. Signature and title of certifier



and manner stated.

5. DIVISON Sheer 1415

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 47094

29d. Date signed (Month, Day, Year)

SALISBURY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dey Lindland Nancy Graham August 17, 2009 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death DORCHESTER DORCHESTER GENERAL HOSPITAL CAMBRIDGE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month Day Year) 06/09/1936 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 🔀 F Maryland 73 220-32-9509 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 🙀 No Delmar Delaware Sussex 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 19940 USA 38606 Woodside Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hob Corbin Clara Sturgis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38606 Woodside Dr., Delmar, DE 19940 Stewart Lindland/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/21/09 Downings Cemetery Oak Hall, VA Donation 5 ☐ Other (Specify) Holloway Funeral Home Professional Association 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd. Salisbury, MD 21804 Immediate Cause (Final disease or condition resulting in death) Sepsis Due (or as a consequence of): chronic obstructive pulmonary disease Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2/2/No 1∏ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 201 No 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and Important; If item 27 is any Injury or other trauonce.

Physician

/Medical

Examiner

10a, State

Director

Funeral

þ

Completed

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Sign

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified</u> at

physician and s the burial-trans ed by the a has been si e 2 should b page certificate this

Examine Physician/Medical ģ Completed Be ပို Certification:

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed death. within 24 hours after death

To the Funeral Director:
completely filled in by the f

Division or Vital Records, P.O. Box 68760,

State

the

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 32. Registrar's Signature

31. Date filed (Month, Day, Year) AUG

(Check only one)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #25, per ME G895 9/17/09 TT
State of Maryland / Department of Health and Mental Hygiene

Amended item#20c, WCHD, 8.25.09 SIJJ

Certificate of Death

Reg. No. 2 | | | | 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vea **Physician** 1804 PM 08 16 2009 **JAMES** SAMUEL LANKFORD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Jican Date of Birth (Month, Day, Year) If Under 1 Year Age (In yrs. last birthday Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** Months Min. 1 🕅 M 2 🗆 F Davs Hours Yrs 222-07-0950 89 DELAWARE JAN.4,1920 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the "Mulcal Exarcine" is ust be rectined at DELAWARE SUSSEX SEAFORD 1 □ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9704 NANTICOKE CIRCLE 19973 AMERICA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1944 – 46 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify:WHITE 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING MACHINE OPERATOR 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be VERLON LANKFORD LOTTIE CULVER ပ 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau NANCY C. BENNETT/DAUGHTER TER | SEAFORD, DELAWARE 19973

20b. Place of Disposition (Name of cemetery, crematory or other place)

AUG 20, 20 3altimore, 20c. Location - City or Town, State 20a. Method of Disposition AUG.20,2009 SEAFORD, DELAWARE ODD FELLOWS CEMETERY d Address of Facility
WATSON-YATES FUNERAL HOME, INC. FRONT & KING STREETS SEAFORD DF 10073

Approximate Interval Between Onset and Death 23a Part 1. Enter the o r complications t aused to aused to aused to aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause Final disease or condition resulting in death) **Physician** Sisdual Internation /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): burial P.O. Box 68760. physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) I □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 2 No 3 Probably 4 Unknown 1 Tes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{Other} \) (Specify) 1XXYes 2≥ No 1-Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury
(Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Hen & within 24 hours after death.

7 To the Funeral Director: A completely filled in by the fu kil, hit his 1 ☐ Yes 2 No death. 2 Accident investigation unkno -6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Scaffeld, DE 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 9704 NANTICOKE Tome Circle 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifique 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) e. Canll St Sxli 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day **Physician** 6:05 P M August 27, 2009 Mary Isabel Love /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Grantsville Garrett Goodwill Mennonite Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 7, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 😿 F Ohio 86 1922 220-16-6557 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Oakland Garrett d 2 should be filed within 72 hours after death with the I th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-traumatic event, the Medical Examiner must be notifi 10a. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21550 1003 Dennett Rd. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Garrett County Elementary/Secondary (0-12) College (1-4or 5+) Health Department Psychologist 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lijury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Daisy Belle Ramsey Wilburt Blake Love ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21520 927 Peat Moss Rd., Accident, MD David P. Ramsey/Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 Removal from State Country Side Crematory Aug. 29, 2009 Davidsville, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Lice 203 S. Second St., Oakland, MD X Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ş 1 | Yes 2 | No 3 | Probably 4 Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has performed? Yes 2 **X** No 1 Yes To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Deat 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Datersigned (Month, Day, Year) 29b. Signature and title of certifier own 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

AUG 3 1 2009 DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

Valen

32. Registrar's Signature

10:25

For	State of Maryland / Department of Health and Mental Hygiene									
1 - For State Registrar	Cer	rtificate of Death	Re	g. No.	03					
1. Decedent's Name (First, Middle, Last)			2. Date of Death							
Nellie E. Lichliter			August	28, 20	O ^{Year}					
4a. Facility Name (If not institution, give street	and number)	4b. City, Town, or Location of Dea	th	4c. County	of Death					
Goodwill Mennonite Ho	ome	Grantsville	Garrett							
Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs		Voar)	9. Birth					

Funeral

Physician

/Medical

Director

death with the Maryland 28a-f show if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any injury or other traumatic event, the Medical Examine.

Saltimore, Maryland 21215-0036

Physician /Medical Examiner

burial-tra the as ed by the attending detached for use as should be page 2 s or Attending Physician: funeral director. After within 24 hours after death To the Funeral Director: filled in by the To the Hospital

Division or Vital Records, P.O. Box 68760.

Examiner place (State or Foreign 1 ☐ M 2 🕱 F Days Feb. 5, 1913 Maryland 170-18-0484 96 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 X Yes 2 □ No Director Salisbury PA Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15558 USA 122 Ord St. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. l □Yes 2 ☑ No f Yes, Give ∕ear or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: þ White 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Salisbury-Elk Lick Elementary/Secondary (0-12) College (1-4or 5+) School District 11 Cafeteria Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Loechel Willard Fay 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36854 S. Ridgeview Blvd., Tucson, AZ Fay Gnagey/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 ☐Removal from State Country Side Crematory Aug. 29, 2009 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Lic P.O. Box 275, Grantsville, MD 21536 V 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) as a consequenc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cor Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death in the past 12 months? 3 □Ectopic pregnancy Day 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 Tes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient J_o 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Muhammad

State

Registrar

31. Date filed (Month, Day, Year)

AUG

31

2009

32 Registrar's Signature

			1- Registrar Certificate of D		nemai mygie Reg.	711114	28750			
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death			
-	/Medic	al	Udessa Koss Manners 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or	Leastion of Dooth	August	18,2009 4c. County of Deatl	11:25am			
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or leading to the contex of the context			Prince (
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 8 / 2 / 192		nplace (State or Foreign			
	Director		2 1 6 - 2 2 - 2 1 8 2 1 M 2 F 8 6 Yrs. Supplemental Suppl		8/2/192	.3	Md.			
	yland now		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
	e Mari	ctor	Md. Prince Georges Seat Pleasant				1 X Yes 2 □ No			
	ith the	Dire	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Co	untry?			
	sath w	eral	109 69th Street 2074		esifu Van er Ne	USA 14. Race - Ame	deen Indian			
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medicial Exaction in the facility of other traumatic event, its Medicial Exaction in the facility of once.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 3 □ Widowed 4 1 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of His If Yes, specify Cubar		Rican, etc.)	Black, White				
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Baltimore,	ages 1 nt of H t: If ite / or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	i		. Location - City or				
Ħ	nit. Partme artme ortani injury		4 □ Donation 5 □ Other (Specify) Washington Nat1 21. Signature of Funeral Service Licensee 22. Name and Address	8 / 3 ss of Facility B 1	1/09 <u>S</u> uford Fu	uitland neral S	. Md ervice			
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			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.	g, such as cardiac	or respiratory arrest,		Approximate Interval Between			
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68760,	tificate be executed g physician and as the burial-transit	i E	De to (a) as a consequence of):				VEARS			
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Вох	ath cel	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	,		23d. Date of deli	very Day Year			
P.O.	w requires that the death cei been signed by the attendir should be detached for use	Physician/N	1 ☐ Yes 2 D No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) — 9 ☐ Unknown		****	World	Day Year			
S, P.	s that ined by a detail	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?			
ğ	en sig				1 ☐ Yes	2 No 3 Pr	obably 4 ☐ Unknown			
Vital Record	e law ru has be le 2 sho	Completed			24a. Was an autopsy	prior to d	topsy findings available completion of cause of			
a F	n: The ficate r, page				performed 1 □ Yes 2 🔀	No death?	2 🗆 No			
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סָ	ding Physician: The Ingrement of the Ingrement of the Ingression o	i T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury	4 Li Nursing Ho	ome 5 Residence 28d. Describe how i		cify)			
sioı	ttendir leath. tor: Af the ful	catic	2 Accident investigation M 1 □ Y	res 2□No						
Division of	by 90 P	Certification: To	4 Homicide determined determined building, etc. (Specify)		28f. Location (Stree City or Town, S	tate)	_			
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	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Me	29b. Signature and title of certifier 29c. License	number	29d.	Date signed (Month	n, Day, Year)			
			1310	269		18-20-1	19			
(BG		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	10.0	mn	01100	1			
	Sta	te	31. Date filed (Month, Day, Year) AUG 24 2009 32. Registrar's Signature August 25. Aparts	urgo	11100	XU'/ 19				
	Registra	ar	AUG 2 4 2009 Seven D. Sarks							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Martinez 47 AM Jeannette Louise 20 /Medical County of Death 4a Facility Name (If no institution, give street and number) 4b. City. Town, or Location of Death Examiner 100 stalt COY 70 9. Birthplace (State or Foreign Country) New Jersey Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Months Days Hours Min. 1 M 2 X F 140-26-6435 76 Director 10/20/1932 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show other traumatic event, the Medical Examinar must be multifued 1X Yes 2 □ No Directo Wicomico Salisbury Maryland 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21801 308 W. London Ave. USA permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify. white þ Specify: 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) provider children's day care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Firefile Emily Immendorf ٩ 19a. Informant's Name/Relationship (Type. Print)
Santos Martinez/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 W. London Ave., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/24/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Parsons Cemetery ature of Funeral Service Licensee 22HOTTOWAY Funeral Home Professional Association ario H. 501 Snow Hill Rd., Salisbury, MD 21804 Compson CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) G-LIOBLASTOMIT MULTIFORME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of The law requires that the death certificate be executed burial-transi Exami and Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Por Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performe certificate 1 □Yes 2 THO 1 Yes e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certificalety filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 □Yes 2 □No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

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To the the

Jeanne

State Registrar

Medical

29a. Certifier

29b. Signature applitte of certifier

WARES attunton BOR 31. Date filed (Month, Day, Year) egistrar's Signature 21 AUG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month. Day. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item Registrar #19b perF. Home 9/1/09 BA Certificate of Death WCHD Registrar #1, per phys, 8/27/09, BA Certificate of Death WCHD Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** Robert Lewis Martin 3:45 P M Robert Louis Martin 2009 24 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Nursing and Rehab. Center Berlin If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 82 Yrs. 8. Date of Birth (Month, Day, Yes) 5/13/192 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 XM 2 ☐ F 214-26-3312 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☑ No Berlin Director MD Worcester 10f Zin Code 10g. Citizen of What Country? 10e. Street and Number 21811 USA 9715 Healthway Dr. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Martin, Robert Louis Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: 2 white 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Fishing 8 Waterman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mamie Peterson John P. Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6545 Health a tem 27 is Rt. 5, Box 683, Salisbury, MD 21801 Cobblestone Ct. Darcel Morris / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of
Important: If it
any Injury or o 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 8/25/2009 Cape Henlopen Crem. Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signat ^{2. Name and Address of Facility} Burbage Funeral Home 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 **□**No 25. Was case referred medical funeral director 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Mann of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day, Year) 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral D completely filled i 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier

BAY+1

State Registrar AUG 2 5 2009

Registrar's Signature

A. park

ENSTERN THILE OR SALISHUPY MOZIENE

			1 - State of Maryland / De State of Maryland / De	epartment of F Sertificate of I		, ,	ene g. No. 2 () () (28753
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death	Dav Year	3. Time of Death
	/Medic		EUGENE OSCAR MOORE	T 611 T		Hugust	21 2009	1100
	Examin	er	4a. Facility Name (If not institution, give street and number)		Location of Death		4c. County of Dea	
_	Funeral		DOCTOR'S HOSPITAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	LANHAM (ay) If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	9. Bi	irthplace (State or Foreign
	Director		226-32-0741 1⊠M 2□F 80 Yrs	Months Days	Hours Min.	(Month, Day, 1/26/19		her Glen, VA
	pug *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	r Location				10d. Inside City Limits
	Maryle f sho	jo						1 X Yes 2 □ No
	r 28a-	Director	DC WASHING	10f. Zip Code		10	g. Citizen of What C	Country?
	th with		837 19th Street NE # 3	2000	02	U:	nited Sta	tes
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Ith Medical Examinational Landing at	Funeral	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Spean, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	ite, etc.
21215-0036	2 hours a natural", c	ted by		ecedent's Usual Occup	ation		Specify: B1,	
21	thin 7 ne. nan "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired	dunng most of work.	ng		
	s should be filed within and Mental Hygiene. is marked other than aumatic event, In M.			ent Mason	18. Mother's Name	/First Middle M	Private_	
ano	intal F ed ot ed ot	Be	17. Father's Name (First, Middle, Last) Samuel Robinson		Alberta I	, , ,	alueri Surriame)	
Ž	should be ind Mental marked c	은		lailing Address (Street			City or Town, State	Zip Code)
<u>8</u>	and 2 s ealth ar n 27 is ner trau			8 Fallston				
re,	ss 1 ar		20a. Method of Disposition 20b. Place of Disposition	isposition (Name of crematory or other place			20c. Location - City of	
Ĕ	Pages 'ment of I		1 12 Burial 2 Li Cremation 3 Li Hemoval from State	ton Nation		2009 S	uitland,	Maryland
Baltimore, Maryland	permit. Pages 1 a Department of Hes Important: If item any injury or othe once.		21. Signature of Funeral Service License	22. Name and Addre	_			P.A. yland 20747
			23a. Part 1. Enter the disease or complications that caused the death. D. not shock, or heart failure List only one cause in each line.					Approximate Interval Between
	Physician	W	Immediate Cause (Final disease or condition	?				Onsel and Death
rd.	/Medical Examiner		resulting in death) de 16 (or as a consequence of):	1. 4.	11	· N		11.10
	Examine	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	tructive	14/Many	11/isa	æ	Unknown
	nsit	Examiner	cause. Enter Underlying		/			
Ć	execu in and ial-tra	Exa	that initiated events ' c	:				
68760,	ificate be executed g physician and as the burial-transit	edical	d					
			IF FEMALE:					
Box	Attending Physician: The law requires that the death certificath. ector: After this certificate has been signed by the attending I by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1	3 Ectopic pregnand 5 Other (specify)	y		23d. Date of o Month	delivery Day Year
<u>Ч</u> О	at the de	Phys	9 Unknown		and a Double	22a Did tab	vacca uca contributa	to the cause of death?
rds,	quires that en signed l uld be det	δ	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause giv	en in Part I.	236. Du 100		Probably 4 Unknown
Vital Record	ne law requii 9 has been s ge 2 should	Completed				24a. Was ar autops perform	y prior t ed? death	
ta	ician: The l certificate ha ector, page		25. Was case referred to medical		26. Place of Deatl	1 ☐ Yes		es 2□No
<u>=</u>	ysician; nis certific director, I	To Be	examiner?	atient 3 DOA Oth	or:		nce 6 Other (S	pecify)
0	ding Phy h. After thi funeral (J:UC	27. nn → of Death tural 5 Pending 28a. Date of Injury (Month, Day, Year) Inju		ry at	28d. Describe ho		
Sio	eath. or: Ai	catic	2 Accident investigation	M 1 🗆	Yes 2□No			
Division of	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office		28f. Location (Str City or Town	reet and Number or n, State)	Rural Route Number,
_	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I		29a. Certifier rtifying Physician: To the best of my knowledge, c					
	To the He within 24 To the Fu	Medical	(Check of Midical Examiner: On the basis of examination and/one) Midical Examiner: On the basis of examination and/one	or investigation, in my o	opinion, death occur			
	To the within To the comple	Σ	29b. Signature and title of certifier	29c. Licens	se number	3/ 25	9d. Date signed (Mo	onth, Day, Year
	0 6		39 Name and addressyof person who completed cause of death (item@3a) (Ty	(pe, Print)	1 1 N	010	1/ /1	1/9/
	Sta	to	Jan 1/4, Michaels un Doctors (- M	Hospital	8/18/600	dlach K	of respect to
	Registr		31. Date filed (Month, Day, Year) AUG 2 5 2009 August A. Agaze					

Moore, Eugene

			State of Maryland / Dep	artment of Health and lertificate of Death		ene 2009	28754
	Physici		Decedent's Name (First, Middle, Last) CARROLL ELLIS MILLER		2. Date of Death Month Aug. 2	2 j ^{ay} 2 j ^{ay} 2 j j	3. Time of Death 10:37 A.M
with the same of t	/Medio		4a. Facility Name (If not institution, give street and number) 49 Deer Park Hotel Rd.	4b. City, Town, or Location of Death Oakland	1	4c. County of Death Garrett	
	Funeral Director		5. Social Security Number 212 12 8324 6. Sex 1 M 2 F 92 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		9. Birthp Coun	lace (State or Foreign try) WV
	he Maryland 28a-f show ptiffed at	ector	Usual Residence of Decedent	, MD.	100	Citizen of What Coun	0d. Inside City Limits 1 □ Yes 2 ☑ No
	h with ti	al Dir	10e. Street and Number 49 Deer Park Hotel Rd.	10f. Zip Code 21550	100	U.S.A.	u y :
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It was a second to the than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantural he notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No if Yes, Give Ye ar or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 M No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White, e Specify: Whi	etc.
21215-0036	filed within 72 hou Hygiene. kther than "natura ant, the Medical E	Completed by	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired) Owner	king	Sb. Kind of Business/Inc Sports Sho Motel &Ser	p
Maryland 3	2 should be filed within and Mental Hygiene. Is marked other than 'aumatic event, tre Me	To Be C	17. Father's Name (First, Middle, Last) Andrew Jackson Miller		ne (First, Middle, Ma Martin	aiden Surname)	
, Mar)	1 and 2 sho Health and I em 27 Is ma other traume		Mary M. Miller 49	ing Address (Street and Number or Ru Deer Park Hotel	Rd. Oakla	and, MD. 21	550
Baltimore,	permit. Pages 1 and : Department of Health Important: If item 27 any Injury or other tr once.		4 □ Donation 5 □ Other (Specify) Garrett M	position (Name of ematory or other place) emorial Gard. 8/3 22. Name and Address of Facility Dar	1/09 Oa	oc. Location - City or To akland, MD. rdock Funer	
8	6 2 E 5		23a. Part 1. Enter the disease, or complications that caused the death. Do not e	21 N. 2nd. St. Oa			Approximate Interval Between
8760,	Physician /Medical Examiner physician and physician and the prival-Itansit into physician and the phys	dical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence)of): Due to (or as a consequence)of): Due to (or as a consequence)of):	dementia systolic hea	rt fai	lure 1	Onset and Death Syears Nany Years
O. Box 6	ath certif attending for use as	Physician/Mec		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ery Day Year
ords, P.	w requires that the de been signed by the should be detached i	þ	Part II. Other significant conditions contributing to death but not resulting in the hypertension i Venous Afau	underlying cause given in Part I.	23e. Did toba	acco use contribute to th	1 4
of Vital Records,	iclan: The law r certificate has by rector, page 2 sh	Completed	Prostate cancer atrial full	26 Place of Do	24a. Was an autopsy performs 1 □ Yes 2	prior to co death? No 1 ☐ Yes	psy findings available mpletion of cause of 2 No
of Vi	hysicle this cert	To Be	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ent 3 DOA Other: 4 Nursing H	lome 5 Residen	ice 6 Other (Specif	(y)
Division o	or Attending Fatter death. Director: After in by the funers	Certification: To	27. Manner of D ath S Natural S Pending investigation	Work? M 1 □ Yes 2 □ No	28d. Describe how 28f. Location (Stre City or Town,	eet and Number or Rura	al Route Number,
	To the Hospital within 24 hours of To the Funeral I completely filled	Medical C	29a. Certifier (Check only one)	ath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner as s te and place, and due to	stated. the cause(s)
	To the withing the To the complex comp	Me	29b. Signalue and title of certifier Murganit a fair M	29c. License number 7.26650	290	d. Date signed (Month, 8-27-69	Day, Year)
_	4	5	30. Name and address of person who completed cause of death (Item 23a) (Type 131. Date filed (Month, Day, Year) 32. Begistrar's Signature	Memorial Dr	Qallas	nd, Med a	1550
Dis	Sta Registi	rar	AUG 2 8 2009 August J.	hadd			

DHMH 17 Rev 1/2001

ORIGINAL

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August **Physician** 2001 Donald Mitchell Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown Washington County Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🕱 M 2 🗆 F Yrs. 180-26-8720 Director June 6,1937 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Medical Examination must be notified at any injury or other traumatic event, if a Medical Examination 10c. City, Town or Location 10a. State Director Maryland Frederick Adamstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 7518 Mountain Approach Road <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: Korean 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No <u>ک</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BAE Systems Technical Editor 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Thomas Mitchell Florence Lindsay 19a. Informent's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Mitchell Jr. / Son 5153 Smith Road, Rohrersville, Maryland 21779 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Stauffer Crematory Inc.8/25/2009 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes 1621 Opossumtown Pike, P. A. Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RESPIRATORY FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RESPIRMORT ACIDOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): HEMORPHAGIC STROKE Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, TPERTENSION

the Hospital or Attending Physician: The law requires that the death certificate be executed

Physician/Medical þ Completed Be Certification: To To the Hospitarwithin 24 hours after death.

To the Funeral Director: Aft

IE EEMALE

23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		topic pregnancy ter (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the under	ying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
URINAM	TRACT INFECTION)	1 ☐ Yes	2 No 3 Probably 4 down
	MELLITHS II		24a. Was an autopsy performed?	
25. Was case referred to medical		26. Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Impatient 2 ER/Outpatient 3	DOA Other: 4 Nursing H	lome 5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	ury occurred
3 Suicide 6 Could not b 4 Homicide determined		factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, te)
	nysician: To the best of my knowledge, death oc miner: On the basis of examination and/or invest and manner stated.			
29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)
Ann		D0062006	(124/04

D0062006

MYGLITOWN MID

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

10d. Inside City Limits

White

1 ☐ Yes 2X No

20 M

State Registrar

cal Medi

DAVID

31. Date filed (Month, Day, Year) AUG 25 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YW			┸
YW	1	Physician /Medical Examiner	
State	Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Madical Cortification. To Be Completed by Dhysician Medical Evaminer
Registra	İ	Sta Regist	ate rar
DHMH 17 Rev 1/200	DH		200

			Plea	se Type or State o				<mark>delible Ink.</mark> artment of H		•		gible.		
	•	For State Registrar			,			rtificate of L		, ,	g. No. 2	009	28756	
Physicia		1. Decedent's Name		e, Last) Charles	Edwar	d Ne	-15	on, Jr.		2. Date of Death Month August	Day	2009 2009	3. Time of Death 10:19 PM	
/Medic Examin		4a. Facility Name (I		n, give street and nu		4 110			Location of Death	magase	10.17			
		1880 01d						Hunting		Calvert				
Funeral Director		5. Social Security N 213-24-3		6. Sex 1 💢 M 2 🗆 F	7. Age (In 78	yrs. last birt	hday) (rs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 02-17-1	Year)	9. Birth Cou Wash	place (State or Foreign intry) D.C.	
מי		Usual Residence of	Decedent							02 17 1	751			
show	٦٢	10a. State	10b. County		10c	. City, Town	or Lo						10d. Inside City Limits 1 ☐ Yes 2 🙀 No	
the M	Director	MD 10e. Street and Nur		lvert		-		Hunting 10f. Zip Code	gtown	10	0g. Citizen	of What Cou	Λ	
h with 23a or		1880 016	lfield	Drive		20639								
r deat	Funeral	11. Marital Status	edent Ever i	in U.S.	13.	Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ameri Black, White,				
2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Madical Exercitive mast be notified at	by F	1 ☐ Never Marri 3 🛣 Widowed		l lf∜be G	2 □ No live Dates: 19	54-62		1∐Yes 2∭XNo	Specify:		Spe	ecify: w	hite	
72 hou natura ical E	ted	/Snoo	15. Deceder	nt's Education est grade completed				dent's Usual Occup			16b. Kind o	f Business/Ir	ndustry	
vithin sne.	Completed	Elementary/Seco			(1-4or 5+)		life. I	DO NOT use retired mbing cor	1)	9	n1	mbing		
filed v Hygie other 1		17. Father's Name	(First, Middle,	Last)	2		pru	IIIDIIII COI	18. Mother's Nam	e (First, Middle, N				
Vental Vental rrked rric ev	To Be	Charles	Edwar	d Nelson	ı, Sr	•			Paulin	e		Crum	ıbaugh	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Macheal Evandinar mast be notified at once.	ľ	19a. Informant's Na						ng Address (Street						
1 and Health em 27		Charles E. Nelson III, son 1880 Oldfield Drive, Huntingtown, MD 206. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or To												
Pages ent of nt: If it ry or c	4 Donation 5 Other (Specify) Metropolitan Crematory 8-27-2009 Alexandria,													
rmit. I spartm portal y Inju	4 Donation 5 Other (Specify) Metropolitan Crematory 8-27-2009 Alexandria, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home,											P.A.		
6 8 3 6 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8	21. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 20 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											'36		
			ırt failure. List	r complications that t only one cause or		death. Do n	of ent	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between Onset and Death	
Physician /Medical		disease or conditio resulting in death)	in	a. Due to	(Mas a cor	nsequence of	rt):	2000						
Examiner		Sequentially list con	nditions	b	0	Sev	Ú							
ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.												
be executed ician and burial-transit	Exan													
eath certificate be executed attending physician and for use as the burial-transit				d										
ding place as t	Physician/Medical	IF FEMALE:		23c. If yes, or	itcome of nr	regnancy						D		
death of atten	ician	23b. Was decedent in the past 12 1 ☐ Yes 2 [months?	1 ☐ Live 4 ☐ Pre	birth 2 🗀 gnant at time	Fetal death		☐ Ectopic pregnanc ☐ Other <i>(specify)</i>	У		230.	Date of deliver Month	Day Year	
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uires than signed Id be de	þ	Part II. Other signif	ficant conditi	ons contributing to	death but not	t resulting in	the u	nderlying cause giv	en in Part I.			_	the cause of death?	
The second secon									topsy findings available					
The la	autopsy performed? l Yes 2 No									ompletion of cause of 2 □ No				
ician: certific ector,	Be	25. Was case refer examiner?		Hospital:				at 3 DOA Oth	or.	th (Check only one				
Phys er this eral dir): To	1 ☐ Yes 2 ☐ 27. Manner of Deat		28a. Date	e of Injury	28b. T	ime o	II 3 LI DOM	4 Li Nursing H	ome 5 Aeside 28d. Describe ho			sify)	
ath. or: Afte	atio	1 ☑ Natural 2 ☐ Accident		igation	nth, Day, Yea	a <i>r)</i> Ir	njury		K? Yes 2 □ No					
or Atter after de Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detern	ained 200. Plac	e of Injury - ding, etc. (S	At home, far pecify)	m, str	eet, factory, office		28f. Location (St. City or Town	reet and No n, State)	umber or Ru	ral Route Number,	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical C	29a. Certifier (Check only one)		ng Physician: To the Examiner: On the and ma										
To th To th	Me	29b. Signature and	title of certifie	06-1	MI	5		29c. Licens	e number 2705	2		gned (Month		
Kg		30. Name and addr	ress of person	who completed cau	use of death			Print)	Price	Fred	deric	J(M)	£7006 d	
Sta		31. Date filed (Mon		32.	Registrar's S	Signature						1 -	0-0-4	
Registr	ar	AUG 2	4 2009	Anus	P A	Barn	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 Physician William Robert Phippin, Jr. /Medical 4c. County of Death Facility Name (If not institution, give street and number) Town, or Location of Death Examiner WICOMIC oice a a If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 XM 2 ☐ F Days 212-78-9289 46 Director 10/08/1962 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the "nadeal Event near must be nutified at once. 1XYes 2 □ No Fruitland Maryland Wicomico Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21826 100 Liberty Way, Apt. 3 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: Navy 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify. 3 X Widowed 4 ☐ Divorced white Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Corian Technician cabinet making 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris Marie Lewis William Robert Phippin Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 S. Main St., Hebron, MD 21830 19a. Informant's Name/Relationship (Type. Print) Doris Phippin/mother 20b. Place of Disposition (Name of cemetery, crematory or other place Springhill Memory 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/19/09 Hebron, MD 4 ☐ Donation 5 ☐ Other (Specify) Gardeñs Funanti Service Licensee Holloway Funeral Home, Professional Association 94. Compson 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** MRTASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending hours and the contract of the strength of the s burial-trar Due to (or as a consequence of): P.O. Box 68760, led by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) I ☐Yes 2 ☐No 9 Unknown 9 Unknown ate has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Probably 4 🗌 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 NO 1 ☐ Yes 1 ☐ Yes ours after death.

Included in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1€ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

State

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30. Name an address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 15 2009

32/ Registrar's Signature

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Physician
/Medical
Examiner

Funeral

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a life it winner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Sta Registr

	Registrar			Cer	tificat	te of i	Death	1		Reg.	No.	0	- U 1	00		
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_	19a. Informant's Name/Relations	ship (Type. Print)		19b. Mailin	g Address	s (Street	and Numb	er or Rui	ral Route Num	ber, Ci	ity or Town	, State, Zij	p Code)			
	Denise Sheila P	uri- Daug	hter	3702	Taylo	or St	. Br	entw	ood M.I).	2072	2				
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	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a such as cardiac or respiratory arrest, interviously.															
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Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier 1 Certifyi	ng Physiology To the	a host of mir. Im.	ladas de-"		N 04 Ab - 2"	mo -1-1-	nd nlc	and due to it		na/a) ===1		stated			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 19^{Day} 2009^{ear} VIVIAN PULLEY 9:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE CRESCENT CITIES NURSING HOME RIVERDALE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year North) | Min. | 03-25-1927 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** NORTH CAROLINA 1 ☐ M 2 🔀 F 82 Director 579-32-9622 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Macical Exeminer most by notified at PRINCE GEORGE Director MD SEAT PLEASANT 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 827 CARRINGTON AVE 20743 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th CLERK GOVERNMENT permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLIE REID CORA B. BATTLE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EDWARD T. PULLEY/HUSBAND 827 CARRINGTON AVE SEAT PLEASANT, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State W Burial 2 ☐ Cremation 3 ☐ Removal from State VETERANS CEMETERY 8-31-2009 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL ROME 21. Signatury Funeral Service Licenser 7474 LANDOVER RD LANDOVER, MD 20785 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Ust only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Temoscley /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ Perinheral antenial 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed ormary avery 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform certificate Chronic Renal 2 1 1 ☐ Yes 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 114 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) AUGUST 20 2009 ame and address of person who completed cause of death (Item 23a) (Type, Print) source Nel Hyattrille MD 20181 ORE MD Y203 Q VREA State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9900 2-25-10 vt State of Maryland/Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JORGE ISAAC DELGADO PADOVANI AUGUST 19 4:40 P^{M} 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH **BETHESDA** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 12, 1975 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 XM 2 □ F 583-436-6600 34 Director Puerto Rico Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mertial Hygiene.
mit: If fiem 27 is marked other than "hatural", or items 23a or 28a-f show Lry or other traumatic event, Ira Murical Expringer manual Expringed and Jury or other traumatic event, Ira Murical Expringer. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at MD Frederick 1 XYes 2 □ No Director Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 40011 Branca Dr. 21702 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 2009 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Puerto Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Rican 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Army Soldier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eudaldo Delgado ပ္ Elizabeth Padovani 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele L. Delgado/Wife 40011 Branca Dr. Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Perez Funeral Home 8/26/09 4 Donation 5 Other (Specify) Puerto Rico 21. Signature of Funeral Service Lieansee 22. Name and Address of Facility Muth Murphy FH 4510 Wilson Blvd.Arl., VA 22203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 1ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. First the conditions of the cause of the ca Examiner Due to (or as a consequence of) **Hospital or Attending Physician:** The law requires that the death certificate be execu 24 hours after death. resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 □Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 □Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature And title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0030712 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

ROBERT L. DANNER

31. Date filed (Month

AUG 2 5 2009

Division of Vital Records,

32. Registrar's Signature

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** LAWRENCE PATTERSON RUSSELL 2009 06:51 AUGUST 20 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Casey House-6001 Muncaster Mill Rd. Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6 Sex Funeral Months 1 X M 2 T F 55 1954 Pennsylvania 198-46-7318 April Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene.
is marked other than "natural", or items 23s or 28s.4.-----10d. Inside City Limits 10c. City, Town or Location 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 Mo Olney Director Montgomery Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20832 4232 Headwaters Lane Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify White δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Insurance Sales Manager 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) Be Smiley Alice L. Patterson Samuel L. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4232 Headwaters Lane, Olney, Md. Valerie F. Patterson / Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Alexandria, Va. 8/21/09 Metropolitan Crem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee Box 5038, Laytonsville, Md. 20882 P. O. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Esophageal Cancer disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and Due to (or as a consequence of) burial-Box 68760 attending physician Physician/Medical the as yes, outcome of pregnancy □ Live birth 2 □ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) law requires that the death Month Year for Day in the past 12 months? Pregnant at time of death 1 ☐ Yes 2 ☐ No P.O. the detached 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. completely filled in by the funeral director, page 2 should be det Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 2 🗆 No 1 ☐ Yes 1 ☐ Yes Physician; 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 1∐Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a Date of Injury 28c. Injury at Work? Certification: Attending (Month, Day, Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Hospital or Attendi 24 hours after death. Funeral Director: A 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier J. Kouatche U m 1) August 20, 2009 D 63748 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, Md. 10 Jocelyne Kouatchou, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar AUG 24

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 25 AM **Physician** 20 Elton Rounds Maurice /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 34/13641 Nicomics REGIONAL If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Yea 2-12-1927 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**∑** M 2□ F Maryland 82 214-28-1593 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State show s 23a or 28a-f shov 1 ☐Yes 2 ☑ No Director Salisbury MD Wicomico 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21801 28158 Log Cabin Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 N Yes 2 No 194

If Yes, Give Year or Dates: 194 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. r than "natural", or items 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1945-Maryland 21215-0036 1 □Yes 21 No Specify Specify: White <u>ک</u> 3 X Widowed 4 ☐ Divorced 1947 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygiene. Own Farm Farmer 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. Be Rounds Bessie Theodore ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10835 Cathell Road, Berlin, MD 21811 Lynn Crockett - Stepson Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8-21-2009 Delmar, Delaware Crematory of Delmarva 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Bounds Fuenral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No P.0. the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an has certificate 2 No 1 ☐ Yes **Division of Vital** 25. Was case referred medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 27. Mann of Death completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number pleted cause of death (Item 23a) (Type, Print) ASTERN STAKE UR SALISTURY MO'UZOG

State Registrar 32. Registrar's Signature

Day, Year)

AUG 21

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:55 AM M Elsie Cooper Rogers 2009 18 August /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Nursing Home Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 □ XF 97 June 16, 1912 Delaware Director 222-07-3365 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 No DE Seaford Sussex Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19973 7113 Woodland Ferry Road USA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Inspector E.I. DuPont/ Nylon 8 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie Hill Thomas Cooper ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7113 Woodland Ferry Road Seaford, De. 19973 Allen Rogers, Jr. son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Asbury Cemetery Aug. 22, 2009 Laurel, Delaware 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 700 West Street Hannigan, Short, Disharoon F.H. Laurel, De. 19956 Holly Short - Jannegas Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final THEROSCLENOTIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed Exam physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Donknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 10 24a. Was an Jas autopsy performe certificate 2 D No Within 24 hours after useu...
Within 24 hours after useu...
To the Funeral Director. After this certifice 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manny of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Whatural (Month, Day Year) 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier not 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahesha Thimmarayappa M.D. 614 Eastern Shore Drive Salisbury MD

Registrar

State

31. Date filed (Month, Day, Year) AUG 2 5 2009

DHMH 17 Rev 1/2001

32. Segistrar's Signature

Registrar

State

31. Date

filed (Month, Day,

AUG 26 2009

Year

32. Registrar's Signature

park

Amended #s 23a(a), 23a(b), nls, per phy., 08/31/09, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

•		1	State Registrar			Cer	tificate of L	Death	R	eg. No.	W 2				
			1. Decedent's Name (First, Middle, La.	st)					Date of Deat Month	h Day	Year	3. Time of Death			
	Physicia		Dorothy	E1	izabeth		Ruble	9	August			1953 ^M			
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location of Death		4c. County	of Death				
	LXaiiiii	•	Upper Chesapeak	e Hospital	Hospital			r			ford				
	Funeral		5. Social Security Number 6. S		7. Age (In yrs. last birthday)			If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp Cour	place (State or Foreign ntry)			
	Director		216-22-5923	□ M 2 💢 F	81	1 Yrs. Months Days Hours Mi				927	Mar	yland			
	О		Usual Residence of Decedent								1	0d. Inside City Limits			
	how	_	10a. State 10b. County		10c. City, Tow	n or Lo						1 □Yes 2 X No			
	a-f s	5	MD Harfo	ord			Joppa								
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, it a Miscical Evandrar must be redified at	Funeral Director	10e. Street and Number				10f. Zip Code	1005	1	I0g. Citizen of V	Vhat Cour USA	itry?			
	23a	a	1218 Old Mount	ain Road,	N			1085							
	dea	ine.	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rac Blac	e - Americ k, White,	can Indian, etc.			
0	after or ite	교	1 ☐ Never Married 2 ☐ Married	1 ∐Yes 2 🔯 If Yes, Give	No		1 □Yes 2 ☑ No	Specify:		Specify	/: _				
3	ral",	d by	3 X Widowed 4 □ Divorced	Year or Dates:					-	405 Kind of D		White			
ה	72 h	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a	(Give	dent's Usual Occup kind of work done	during most of work	ring	16b. Kind of Bu	usiness/in	dustry			
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yland	Meni Meni arked	၉	George Sh	nepherd											
Mar	2 sho and is ma		19a. Informant's Name/Relationship	(Type. Print)				and Number or Ru				_			
Σ	and 2		Mark Ruble / Son					ntain Roa	nd, N, J	oppa, M 20c. Location -	D 2	1085			
or e	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is insided Evaning must be 13 titled at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Demoval from State	cemete	əry, cřer	sition (Name of natory or other pla	ce)			•				
Бантітог	Pag nent int; I		4 □ Donation 5 □ Other (Speci		Pleas	Grove Ce	29/2009 Cumberland, MD Adams Family Funeral Home, P								
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	/Medical		disease or condition resulting in death)		a consequence		103	1			- 1				
	Examiner			Hyper	tension										
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Box	n cer endin use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal dea	th 3í	☐ Ectopic pregnan	cv			ate of deli				
n	death ne atter ed for u	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 🗌 Pregnant	at time of death		Other (specify)			IVI	onth	Day Year			
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Records,	w require s been si should b	Completed							24a. Was	an 24b.	Were au	topsy findings available completion of cause of			
Re	he la e has ige 2	ᇤ							autoj perfo 1 □Yes	rmed? 🔟	death?	2 □No			
g	n: T ificat or, pa		25. Was case referred to medical					26 Place of Dea	ath (Check only o		10103	2 🗆 110			
5	sician: The law s certificate has b lirector, page 2 s'	Be	examiner?	Hospital:	ient 2 ER/0	Jutnatie	ant 3 DOA Ot	h	lome 5 ☐ Resi		ther (Spec	cify)			
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Division of Vital	Attending Physician: The law requires that the rdeath. ector: After this certificate has been signed by the tuneral director, page 2 should be detached.	lica	3 ☐ Suicide 6 ☐ Could not	be 280 Place of It	njury - At home,	farm, st	treet, factory, office		28f. Location (Street and Num	ber or Ru	ıral Route Number,			
.≥	l or Attend after death Director; /	Certification: To	4 ☐ Homicide determine	building, e	etc. (Specify)				City or To	wn, State)					
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; / completely filled in by the fi		29a, Certifier 1 Certifying	Physician: To the bes	t of my knowled	lge, dea	th occurred at the	time, date and plac	e, and due to the	cause(s) and r	nanner as	stated.			
	24 h Fun etely	Medical	(Check only 2 Medical Ex	aminer: On the basis and manner:	of examination	and/or i	nvestigation, in my	opinion, death occ	urred at the time,	date and place	, and due	to the cause(s)			
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Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1710 M August 18, 2009 Geneva M Riley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montogomery Holy Cross Hospital Silver Spring 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 □ M 2 🔽 F 2-10-1915 Maryland Director 94 579-09-7345 Usual Residence of Decedent with the Maryland 10d. inside City Limits 10c. City, Town or Location your j 10a. State 10b. County d other than "natural", or items 23a or 28a-f shov event, the Medical Exandrac must be redified at 1 Yes 2 No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20910 United States 8906 16th Street death v by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 □Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Secretary 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard McReynolds Mary Barnett ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring M.D. 20910 Janet Stevenson/daughter 8906 16th St. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 5 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any Injury or once. Fort Lincoln Cemetery: 8-27-2009 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature Funeral Service Cen 3401 Bladensburg Rd Brentwood MD 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner The law requires that the death certificate be executed Congestive Heart Failure signed by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2K No 1 □Yes 2X No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1₺ Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation n 24 hours after deach.

The Funeral Director Af pletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital 29a. Certifier 1 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 24 hou **To the Fune** completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D60826 8/19/2009 Eshama Gang 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kshama Garg, M.D. 1500 Forest Glen Road Silver Spring MD 20910 31. Date filed (Month, Day, Year) AUG 2 5 2009 32. Registrar's Signatur State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1 - State Registrar		-	Cei	tificate	e of L	Death		,	Reg. No.	2009	28/6	
Physici /Medic		1. Decedent's Name (First, Middle,		David Ric	hardson				2	. Date of Dea Month Au	eth gustal	1, 2009 ar	3. Time of Death	
Examir		4a. Facility Name (If not institution,	give street and numi	_		4b. City, 7	Town, or	Location of D	eath imber	land	4c. C	County of Death	legany	
Funeral Director		5. Social Security Number 214-88-9390	6. Sex 1 M 2 □ F	. Age (In yrs. 46	last birthday) Yrs.	Months Days Hours Min (Months Day						th 1991963 9. Birthplace (State or F Country) ary land		
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland	Allegany	10c. City	y, Town or Lo	cation		Cumber	land			1	0d. Inside City Limits	
h with the	Funeral Director	10e. Street and Number	6 Decatur Stre	et		10f. Zip	Code	2150	2		10g. Citiz	en of What Cour	ntry? SA	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Evantium must be notified at once.	by	11. Marital Status 1 □ Never Married 2 Marrie 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 □ Yes 2 If Yes, Give Year or Dat	es? No		If Yes, specify Cuban, Mexican, Puerto Rican, etc 1 □ Yes 2 No Specify:						14. Race - American Inc Black, White, etc.		
ed within 72 h ygiene. ier than "natu t, in "Malcal	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4	8 ^{r 5+)}	(Give	(Give kind of work done during most of working life. DO NOT use retired) LUDOIL V							dustry L	
ould be file Mental Harked oth arked oth	To Be	Allocit Julius Highlandson									aiden Surname) onna Johnson			
and 2 sho salth and n 27 is mi er traum		19a. Informant's Name/Relationship (Type. Print) Terri Richardson - Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta 306 Decatur Street, Cumberland, Marylan										Jown State, Zir laryland, 2	1502	
Pages 1 and the part of He part of He part of He part of the part		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		ate 20b. P	Place of Dispo emetery, cren Ot	sition <i>(Nam</i> natory or ot ik Hill C	e of her place emete	ry	Dat	August 25, 2009	20c. Loc	ation - City or To Lonaconir	own, State ng, Maryland	
permit. Departr Imports any Inju		21. Signature of Funeral Service L	icensee	∞	22	. Name and		s of Facility Cast Main	Stree			cKenzie Fu ng, MD 21	meral Home P. 539	
Physician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Am	used the death ch line. O TAO r as a consequ	PHIC	-	e of dyin		_	respiratory ar			Approximate Interval Between Onset and Death	
eath certificate be executed attending physician and for use as the burial-transit	Medical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequ										
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quires that n signed b	d by Phys	Part II. Other significant condition	ns contributing to dea	th but not resu	ulting in the ur	nderlying ca	use give	en in Part I.			obacco us		he cause of death?	
To the Hospital or Attending Physician: The law requires that the death within 24 hours after dea h. To the Funeral Director After this certificate has been signed by the attencompletely filled in by the funeral director, page 2 should be detached for under the funeral director, page 2.	Completed								_	24a. Was autop perfo 1 ∐Yes		24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available mpletion of cause of	
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hysl this c	၉	1 Yes 2 No	Hospital: 1 In	patient 2	ER/Outpatier	t 3 □ DO.	A Othe	er: 4 🗆 Nursi	ng Home	5 Resid	lence 6	☐Other (Speci	(y)	
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To the Hospitali or Attentivitin 24 hours after deal. To the Funeral Director		4 ☐ Homicide determin	ned 28e. Place o	f Injury - At ho g, etc. <i>(Specif</i>)	y)					City or Tou	vn, State)		al Route Number,	
he Hosp in 24 hot he Fune pletely fil	Medical	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical E	Physician: To the base xaminer: On the base and manner	sis of examina	wiedge, deati tion and/or in	occurred a vestigation,	at the tin in my o	ne, date and pointion, death	olace, ar occurred	d due to the I at the time,	cause(s) date and p	and manner as place, and due t	stated. o the cause(s)	
To t with To t	Σ	29b. Signature and title of certifier	\			29c.	. License	number		29d. Date signed (Month, Day, Year)				

AUGUIT 22, 2009

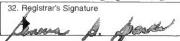
30. Nome and addr ss of person who completed cause of death (Item 23a) (Type, Print)

Drive, Cumberland, MB 21502

1) 42054

State Registrar

Donaldson m.b. 31. Date filed (Month, Day, Year) AUG 26



DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month AUGUST 22 Day 2009 Physician BRENT DAVID ROBBINS :30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months 55 Director 295-56-9029 August 16,1954 Michigan Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show 10a. State ir than "natural", or items 23a or 28a-f shov The Desireal Examination of the confided at 1 X Yes 2 □ No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 311 Heather Ridge Drive 21702 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Exacutor. Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto Parts Manager Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald W. Robbins, Sr. Emma Dell Fogt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie M. Robbins / Wife 311 Heather Ridge Dr. Frederick, MD 21702 20a. Method of Disposition 20c. Location - City or Town, State August 27, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Frederick, Maryland 21. Signature of Meral Service Diensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death o plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate C e (Final disease or condition resulting in death) SE SIS **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 Unknown signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? anlyr 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 2 No 1 □Yes Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Lakhrinder Wadhwa 400 West 7th Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar AUG 25

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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		For State Registrar	State of I	Maryland / Dep Co	partment of F ertificate of		lental Hygie Reg.	20116	28769
Physicia	an l	1. Decedent's Name (First, Middi	le, Last)				Date of Death Month	Day Year	3. Time of Death
/Medic		Harold Rosenbe					August 20		3:25 P M
Examin	er	4a. Facility Name (If not institution College View N	-		4b. City, Town, o	r Location of Death		4c. County of Deal Frederic	
Funeral Director		5. Social Security Number 091–30–2700		Age (In yrs. last birthda 70 Yrs.			8. Date of Birth (Month, Day, Ye July 10,		
		Usual Residence of Decedent					July 10,	1737 New	TOTK
yland how		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
a-f s	cto	Maryland Fre	derick	Point	of Rocks				1 □Yes 2 🛣 No
or 28	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
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er de	Funeral	11. Marital Status	12. Was Decede		 Was Decedent of I If Yes, specify Cub 	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Eveninal roust by redifficed at once.	Be	17. Father's Name (First, Middle,				18. Mother's Name	e (First, Middle, Maid	den Surname)	
d Mei marke	ဥ	Joseph Rosenber 19a. Informant's Name/Relations		10b Ma	lling Addraga (Street		al Route Number, Ci	ity or Town State	Zin Codo)
id 2 si Ith an 27 is i		Linda Rosenberg							
f Hea f Hea ftem 2		20a. Method of Disposition	y wire				of Rocks,	Location - City or	
Pages ent o nt: If i		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		ate Kes	position (Name of rematory or other pla sthaven al Gardens	Aug.		rederick	Maryland
permit. Departm Importa any Inju		21. Signature of Funeral Service					Servics, S		
89 = 29		1					Hwy. Fred		D 21701
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Physic this c	မှ	1 Yes 2 No	Hospital: 1 🗆 Ing		ient 3 🗆 DOA		ome 5 Residenc		ecify)
ding I h. After funer	tion	27. Manne of Death 1 Natural 5 Pendii	ng 28a. Date of (Month, igation	Injury 28b. Time Day, Year) Injur	y Wo	ıryat ırk? ∐Yes 2∐No	28d. Describe how i	injury occurred	
Atten deat octor:	fica	3 Suicide 6 Could		Injury - At home, farm, , etc. (Specify)			28f. Location (Stree		ural Route Number,
s after	Certification:	4 ☐ Homicide determ	building	, etc. (Specify)			City or Town, S	State)	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical (29a. Certifier 1 Certifyi (Check only one) 2 Medica	ing Physician: To the b i Examiner: On the bas and manne	is of examination and/o	eath occurred at the to investigation, in my	time, date and place opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
To th withir To th	Me	29b. Signature and title of certifie	er C		29c. Licen	se number	29d.	Date signed (Mon	th, Day, Year)
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5		30. Name and address of person	n who completed cause	of death (Item 23a) (Typ	e, Print)			7.41	th, Day, Year) 2170 VICIC 145
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Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sta Registra

	- State Registrar				C	Certifica	te of	Death			Reg.	No.			
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ו	Helen		Seek							June Month	3	Day	2009	1:45	РМ
l r	4a. Facility Name (If		n, give street and nur	mber)		4b. City	ty, Town, or Location of Death Jefferson 4c. County of Death Frederick								
				7 1 - 4	111-4	() If Linds			24 Hre	0 Data of D	lusts.				
	5. Social Security Nu 578-12-04		6. Sex 1	7. Age (In yrs. 90)		Months Days Hours Min. (Month, Day, Year) Country)						_			
				90	, 113	·				April	11	1919	Ma	aryland	
	Usual Residence of I	10b. County		10c C	ity, Town o	r Location			_					10d. Inside Ci	tv Limits
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5	10e. Street and Num		- 5			10f. Zi	p Code	011			10g.	Citizen of		•	
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2	3 🔀 Widowed 4	Divorced	If Yes, Gir Year or D	ve ates:		1 Li Yes	2 M No	Specify				Specil	fy: V	MILLCE	
TO be completed by runeral billector		15. Deceder	nt's Education		16a. D	ecedent's Usi	ual Occup	ation			16b	. Kind of B	lusiness/l	Industry	
3	(Special Special Speci		st grade completed)	Aor E.	- (G	Give kind of wi fe. DO NOT L	ork done Ise retire	during mos d)	st of work	ing					
5	12	idary (0-12)	College (1	-40(5+)	:	Homema	aker					Own	n Hor	me	
3	17. Father's Name (/	First, Middle,	Last)					18. Moth	er's Name	e (First, Middi	le, Maio	den Surnar	ne)		
1	Harvey	Taylo							Ethel						
•					105.11	lailing Addr	n /C4 1	and Non-t	or or D	nl Pouts M	har C	hear T-	Ctct	Zin Cod-1	
	John Fine					lailing Addres						•			
		<u>-</u>	SOII	T	_	516 Fi								20882	
	20a. Method of Disp		3 ☐ Removal from	State 20b.	Place of Di cemetery,	isposition (Na crematory or	ime of other pla	ce)	I	Date	200	. Location	- City or	Town, State	
	4 □ Donation				tropo	olitan	Crem	1.	6/5	5/09	Z	lexa	ndria	a, Virg	inia
	21. Signature of Fur	neral Service	Licensee			22. Name a	nd Addre	ss of Facili	ity	-					
	OCOL	w.	Saule							Funera Laytor			БМ	20882	
	23a. Part 1. Enter th	e disease, o	r complications that of	aused the dea	th. Do not								PIC.	Approximate	e
	shock, or hear Immediate Cause (f	t failure. List	t only one cause on e	ach line.		4	/	7			,			Interval Bet Onset and I	
disease or condition										1 wee	K				
	resulting in death)		Due to	(or as a conse	quence of):	:	. 1	4		<u></u>					
	Sequentially list con	ditions	ьС	e) rona	my		ery.	des	llas	l				year	10
	Sequentially list con if any, leading to immo cause. Enter Under	nediate lying	Due to	(or as a conse	quence of):	•	1							,	
5	that initiated events	njury	С												
١	resulting in death) L	ast	Due to	(or as a conse	quence of):	•									
2			d												
VINCUICAI EXAIIIIIE			-38									1			
	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, out									23d. Da	ate of del	livery	
מ	in the past 12 r 1 ☐ Yes 2 🔽	nonths?		birth 2 Tet nant at time of		3 ☐ Ectopic 5 ☐ Other (s	pregnance pecify) _	су				M	lonth	Day	Year
2	9 ☐ Unknown	1110	9 □ Unkr			,	, , , , ,								
be completed by ringsicia	Part II. Other signifi	cant conditi	ons contributing to d	eath but not re	sulting in th	ne underlying	cause giv	en in Part	l.	23e. Did	d tobac	co use cor	ntribute to	o the cause of c	death?
3	Carob	201/11	1 4	isease		4000	1			10	Yes	2 No	3□ Pr	robably 4 □ I	Unknown
ונו	1	1 1	1			yper	10/10	J. U.							
1	hyper	lipide	mea, 1	upon	yro	idism				24a. Wa	as an lopsy	24b.	Were au	utopsy findings completion of c	available ause of
5	('	•			'					pei 1 □ Yes	formed		death?	s 2□No	
١	25. Was case referre	ed to medica	ıl					26. Plac	e of Deat	h (Check onl)					
5	examiner? 1 ☐ Yes 2 ☑	No	Hospital:	Inpatient 2	BR/Outp:	atient 3 🗆 🗆	Oth	or:		ome 5 Re		e 6∏∩	ther (Sno	ecify)	
:	27. Manner of Death	1	28a. Date	of Injury	28b. Tim	ne of	28c. Inju	ry at	Turoning Tit	28d. Describ				OII y	
5	1 Natural	5 Pendir	/4.4	th, Day, Year)	Inju	ıry M	Wor	ḱ? lYes 2.⊑]No			. ,			
3	2 ☐ Accident 3 ☐ Suicide	6 Could	not be	of Injury - A+ F	nome farm					28f Location	(Stron	t and Num	her or P	ural Route Nun	nhor
	4 Homicide	deterr	nined 20e. Flace build	of Injury - At I ing, etc. <i>(Sp</i> ec	ify)	, ander, Idelo	y, onice			City or T	own, S	State)	PEI OI HI	arai ribute Null	יוסמי
3	20 0 17														
3	(Check only		ng Physician: To the I Examiner: On the b	asis of examin											s)
Medical Celulication: 10	one)		and man	ner stated.											
É	29b. Signature and t	title of certifie	er			25	9c. Licens	se number			29d.	Date sign	ed (Mont	th, Day, Year)	
	Kath	4 loen	W Ster	MI			D:	320	13		(6/4/	200	9	
	30. Name and addre	ess of person	who completed caus	se of death (Ite	m 23a) (Tv	/pe, Print)	-				1	1.1.		*	
	Kathloon	n W.	Stern	MD.	6/0	Nin	th .	aver.	. RI	unsin	nch	· M	d	217/0	0
	31. Date filed (Monta	h, Day, Year,		gistrar's Sign				1				- (
	•	27891 0		A agrant .	M	Marke									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 38 PM ean 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 550 Rose Hill Avenue, Apt A Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Months Days 1 □ M 2 ▼ F 78 21**7-**28**-**9803 08/21/1931 Marvland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ¥ Yes 2 No MD Allegany Cumberland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 550 Rose Hill Avenue, Apt A 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Administrative Associate Municipality 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Russell Clemma Clarence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17600 Breakneck Road, Flintstone, MD Suzanne Norton / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Laurel Hill Cemetery 08/31/2009 Barton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final failure to thrive mouter disease or condition resulting in death) Due to (or as a consequence of) ears OPD Sequentially list conditions, it and be cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Vear Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No

law requires that the death certificate be executed Box 68760, P.0 Division of Vital Records,

burial-tran and cate has been signed by the attending physician page 2 should be detached for use as the buria certificate has Hospital or Attending Physician: The l 24 hours after death. Funeral Director: After this certificate ha stely filled in by the funeral director, page completely

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

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Examine

Physician/Medical

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Completed

Be

Certification: To

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Marical Examiner must be notified at

permit. Pages 1 and 2 sh Department of Health and Important; If item 27 Is n any Injury or other traun once.

Physician

/Medical

Examiner

2 should be filed within 72 hours after death with to and Mental Hygiene.

Is marked other than "natural", or items 23a or ?

Baltimore, Maryland 21215-0036

To the Hospital within 24 hours a To the Funeral C 3

nRs

State

Registrar

29b. Signature and title of certifier Hma Stratul MI)

investigation 6 Could not be

determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

🔯 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D46346

29d. Date signed (Month, Day, Year) August 27, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Huma Shakil, M.D., 625 Kent Avenue, Cumberland, MD

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

		1	For State Registrar	ate of Maryland	•	rtment of H t <i>ificate of L</i>			ene g. No. 2009	28772
	Physicia	_	1. Decedent's Name (First, Middle, Last) John	Stankan				2. Date of Death Month AUGUST	26, 2009	3. Time of Death 13:26 M
	/Medic Examin		4a. Facility Name (If not institution, give street WMHS - MEMORIAL CAM			4b. City, Town, or CUMBERL			4c. County of Deal	
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 M	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05/13/1		thplace (State or Foreign ountry) nnsylvania
	ъ	or	Usual Residence of Decedent	10c. City,	Town or Loc	ation edford				10d. Inside City Limits 1 □Yes 2 🕱 No
	with the N	al Director	10e. Street and Number 158 Centerville	Road		10f. Zip Code	5522	10	g. Citizen of What Co USA	puntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, I w. Medical Erra in a must be notified at ance.	y Funeral	1 □ Never Married 2 🏋 Married	Vas Decedent Ever in U.S. Armed Forces? ☐Yes 2 X No f Yes, Give /ear or Dates:		Vas Decedent of Hi Yes, specify Cuba □Yes 2 XNo	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
21215-0036	hin 72 houn e. an "natural'	Completed by	15. Decedent's Education (Specify only highest grade co	n !	(Give I life. E		luring most of work)		6b. Kind of Business	/Industry
and 21	be filed wit ntal Hygien ed other the event, me	Be	9 17. Father's Name (First, Middle, Last) John	Stankan	Owr	er/Opera	tor 18. Mother's Name Bridget	e (First, Middle, M	Restaur Haiden Surname) Galent	
Maryland	od 2 should aith and Me 27 is marke r traumatic	2	19a. Informant's Name/Relationship (Type. John J. Stankan / S		19b. Mailin 359	g Address (Street a Sandston	an <i>d Number or Rur</i> e Road, I	al Route Number, Bedford,	City or Town, State, PA 15522	
Baltimore,	Pages 1 ar nent of Hes ant: If item ury or othe		20a. Method of Disposition 1 I Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	oval from State 20b. Pla ce Sun	set Me	sition <i>(Nam</i> e of natory or other plac emorial P	e) ark 08/31	1/2009	Cumberlan	id, MD
Balti	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	amó	40	04 Decatu	r Street	, Cumberl	Land, MD	Home, P.A. 21502
Į,	Physician		23a. Part 1. Ener the disease, or complicate shock, or heart failure. List only one commediate Cause (Final disease or condition resulting in death)	ASPIRATI	IDN	FN 2	UMON	CA	st,	Interval Between Onset and Death
	/Medical Examiner	er		Due to (or as a consequence to (or as a consequence)						
,0928	ficate be executed physician and s the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					
O. Box 687	ath certi attending or use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) 9 \(\text{Unknown} \)	If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 [Ectopic pregnanc Other (specify)	y		23d. Date of d	elivery Day Year
σ.	w requires that the de s been signed by the a should be detached i	ρ	Part II. Other significant conditions contrib	uting to death but not resu	ilting in the u	nderlying cause giv	en in Part I.	23e. Did tob		to the cause of death? Probably 4 Unknown
Il Recor	The law ate has t page 2 s	Completed						24a. Was ar autops perforr 1 □Yes 2	y prior to ned? death?	autopsy findings available o completion of cause of es 2 \sumbox No
of Vita	ding Physician: Th. h. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑No 27. Manner of Death	oital: 1 ☐ Inpatient 2 ☑ 28a. Date of Injury	ER/Outpatie		ner: 4 Nursing H		e) ence 6 □ Other (Sp ow injury occurred	pecify)
Division of Vital Records,	tending eath. tor: After the funer	1 0 1 Accident Supplied 6 Could not be 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								Rural Route Number,
٦	Hospita 4 hours Funeral tely fille	ledical Ce	29a. Certifier 1 Certifying Physic (Check only one)	an: To the best of my knows: On the basis of examination and manner stated.	wledge, deat tion and/or ir	th occurred at the ti	ime, date and place opinion, death occu	e, and due to the d irred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the within 2	Me	29b. Signature and title of certifier	9 San	a 1	29c. Licens	se number 14865	2	9d. Date signed (Mo	nth, Day, Year)
	nes		30. Name and address of person who comp BARRERA, ROBUSTIAN	Ø, M.D., 500	MEMOI	RIAL AVEN	UE, SUITI	E 201, CU	JMBERLAND,	MD 21502
	St Regist	ate rar	31. Date filed (Month, Day, Year) AUG 28 2009	32. Registrar's Signa	face.					

		•	For State Registrar	State of Maryland		rtificate of			eg. No.	19	28113
	Physicia	_	1. Decedent's Name (First, Middle, Last) Annette	Shelton				2. Date of Deat Month	h Day 19 20	Year 09	3. Time of Death 0035
	/Medic Examin		4a. Facility Name (If not institution, give s			**	or Location of Death		4c. County		
<i>'</i>			Laurel Region				ure1	O Data of Dinth			eorges place (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1578-80-6443	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 01-10-	1961	Cour	h.,D.C.
	p >		Usual Residence of Decedent 10a, State 10b, County	10c City	, Town or Lo	cation				1	0d. Inside City Limits
	aryla shov	آر م			Lau						1 ∑ Yes 2 ☐ No
	28a-1	rect	MD Prince 10e. Street and Number	Georges	Бац	10f. Zip Code		1	0g. Citizen of W	/hat Cour	ntry?
3	3a or	Ö	228 Patuxent R	oad		2	20707		US	SA	
	death ms 2	Funeral Director		12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of I	Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-		e - Americ k, White,	can Indian,
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At the Maryland I hear 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Marical Evential or in united and or other traumatic event.	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔂 Divorced	1 ∏Yes 2 MNN If Yes, Give Year or Dates:		I □Yes 2X No		, , , , , , , ,	Specify		lack
5	2 hou atura		15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occu	pation	kina	16b. Kind of Bu	siness/In	dustry
7	thin 7 an "n	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of worked)		Hea1th		o Tad
7	ed wii lygien ler th	S	12		Mamm	ogram (Coordina	tor ne (First, Middle, I			e ma.
	12 should be filed within 7 h and Mental Hygiene. 7 is marked other than " traumatic event, the Medical mandle.) Be	17. Father's Name (First, Middle, Last) Hilliard Shelt	on				Belle F		-,	
<u> </u>	should ad Me mark matic	မ	19a. Informant's Name/Relationship (Ty		19b, Mailir	ng Address (Stree	t and Number or Rue			State, Zij	o Code)
2	and 2 s ealth al n 27 is ner trau		Shamika Shelton			Pionee rn, Mai		21144			
ע	is 1 an		20a. Method of Disposition	20b Pl	ace of Dispo	sition (Name of	- i	Date	20c. Location -	City or To	own, State
	Pages ment of I ant: If ite ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		ningt emete	natory or other pla on Nati	10na1 08-2	9-2009	Suit	land	MD
<u> </u>	permit. Pages Department of Important: If it any injury or once.		21. Signature o Funeral Sorrice bicens		R 2	Name and Addr 1ph Wi	ess of Facility	I Funer	ral Se	rvic	e, P.A.
٥	207 20		* Kalghe Us	Margy	52	02 Pri	ncetonsD	elightI	Dr., Boy	vie,	MD 20720 Approximate
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death ne cause on each line.	. Do not en	er the mode of dy	ing, such as cardiad	or respiratory an	rest,		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Lung	Canco	r					
	Examiner			Due to (or as a consequ		stasis					
		je	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ		1504515					
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	GI B1	eedir	ıg					
Ş	icate be executed physician and s the burlal-transit		resulting in death) Last	Due to (or as a consequ	ence of):						
09/90	ate b	edical		d							
Š	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burlal-transit	/Mec	IF FEMALE:	23c. If yes, outcome of pregna	ncv				23d Da	te of deliv	/en/
ğ	eath certifi attending for use as	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3	☐ Ectopic pregnar ☐ Other (specify)	псу			nth	Day Year
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τ.	w requires that the de been signed by the should be detached	by Pt	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause g	iven in Part I.	23e. Did to	bacco use cont		the cause of death?
ğ	quire: en sig uld br	ed b						1 🗆 Y	′es 2 □ No	3 ∏ Pro	bably 4 Unknown
ပ္သ	aw as b 2 s	Completed						24a. Was a	sy	prior to co	opsy findings available ompletion of cause of
Ĭ	The ate h page	l E							rmed? 2 ∰ No	death? 1 🔲 Yes	2 🗆 No
Vital Records,	slcian: The certificate irector, pag	Be (25. Was case referred to medical examiner?	11			thor:	ath (Check only o			
ō	shysta this c al dire		To tes ZixiNo	Hospital: 1 Napatient 2 1	ER/Outpatie	III 3 L DOA		lome 5 ☐ Resid			ify)
ב	ding Phys h. After this funeral dir	ion	27. Manner of Death 1 XNatural 5 Pending investigation	(Month, Day, Year)	Injury	W	ork? □Yes 2□No	200. 2000201			
Division	O	ficat	3 Suicide 6 Could not be	28e. Place of Injury - At ho	pme, farm, st			28f. Location (S	Street and Numb	er or Ru	ral Route Number,
<u>S</u>	after after Dire d in b	Certification: To	4 Homicide	building, etc. (Specif	у)			City or Tou	m, State)		
	Hospital or Atter 24 hours after dea Funeral Director etely filled in by the	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Example	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, dea ation and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place,	anner as and due	stated. to the cause(s)
	To the Hos within 24 hor To the Fun completely	Med	29b. Signature and title of certifier	and marrier stated.		29c. Lice	nse number		29d. Date signe	d (Month	, Day, Year)
	ĕ≱≓ŏ) cut	TAK		D	60936		08-19	-200	09
Š	/n		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type	, Print)				MD.	20707
14	- 10		Abdul Tak, MD Hi	NG of PG Cou	inty	7300 Va	n Dusen	Rd. La	urel,	MD ———	20707
		ata	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature						

AUG 2 5 2009 Seven A. Janes

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		epartment of F Certificate of I			iene _{eg. No.} 20 (9 28774
	Physicia	an	Decedent's Name (First, Middle, Last) ELEANOR FAY STEMP	or E				Date of Deat Month	Day Y	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death	Aug.	27 20 4c. County of	Death
7			Garrett County Mem			Oaklan			Garre	
	Funeral Director		5. Social Security Number 6. Sex 1□	7. Age (i]м 2 ड F 90	In yrs. last birtho Yrs	Months Dave	If Under 24 Hrs. Hours Min.	April 1. Day) [/] •1/919	Birthplace (State or Foreign Country) W
	and w		Usual Residence of Decedent 10a. State 10b. County	1/	0c. City, Town o	r Location				10d. Inside City Limits
	Maryl a-f sho	ctor	MD. Garrett		Oakland					1ÆYes 2□No
partimore, Maryland ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Event har ust be nutflind at once.		Funeral Director	10e. Street and Number 309 Woodland Dr.			10f. Zip Code 2155	0		0g. Citizen of What J.S.A.	at Country?
		by Funer	11. Marital Status 1 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ∐Yes 2 No If Yes, Give Year or Dates:	er in U.S.	 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No 	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	Black,	American Indian, White, etc. White
212-0030	nin 72 hou e. In "natura Medical E	Completed	15. Decedent's Educ (Specify only highest grade	cation e completed) College (1-4or 5+)	(G	ecedent's Usual Occup live kind of work done of fe. DO NOT use retired	during most of work f)	king	16b. Kind of Busin	ness/Industry
7	led with lygiene her tha		11	College (1-401 5+)	Ca	feteria wo		(First Middle A	School	
yland	d be fil ental H ked otf ic even	To Be	17. Father's Name (First, Middle, Last) William A. Johnso	ın			18. Mother's Nam	ne <i>(First, Middl</i> e, M	Maiden Surname)	
ary	shoul and M is marl aumati	F	19a. Informant's Name/Relationship (Typ		19b. M	ailing Address (Street			, City or Town, St	ate, Zip Code)
e, S	1 and 2 Health em 27 ther tr		Donald W. Stemple			1 Palmer L		and, MD.		ty or Town, State
апппо	Pages nent of nt: If it ry or o		1	emoval from State		sposition (Name of crematory or other place: Mem. Gard	i			
Dalt	permit. Departm Importa any inju		21. Signature of Funeral Service License	1 un dock	7		ss of Facility Day		ırdock F	uneral HomeP.A.
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the e cause on each line.	e death. Do not	enter the mode of dyir	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	54	stolic h.	eart fa	ilure	2	Onset and Doam
	Examiner		Sequentially list conditions b.	Chron	ic St	1stolic	heart 1	Ciliu	2	
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence of):	vtore o	isanca			
Ď.	e execu ian and irial-tra		that initiated events c. resulting in death) Last	Due to (or as a co	onsequence of):	raya	Colors			
00/00,	icate by physical the bu	edical	↓ d.	Myper	rtens	ion		_		
O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death, within 24 hours after death, within 24 hours after death, the this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	sician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown/	3c. If yes, outcome of p 1 Live birth 2 4 Pregnant at tin 9 Unknown	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у		23d. Date Monti	
,	ss that t gned by se detac	by Phy	Part II. Other significant conditions con-	tributing to death but n	//	1 1 1 - 1 -	en in Part I.	23e. Did tob	pacco use contrib	ute to the cause of death?
cords,	require		atrial fibrille	270N, C	old Cere	edral vas	x acras			Probably 4 Unknown
ם ו	scertificate has to irector, page 2 si	Completed						24a. Was ai autops perforn 1 □Yes	y prie ned?≄ dea	ere autopsy findings available or to completion of cause of ath? Yes 2 \sumbox No
= :	ysiciar is certif directo	o Be	25. Was case referred to medical examiner?	ospital:	2 🏻 ER/Outpa	atient 3 DOA Oth	041	th <i>(Check</i> o <i>nly</i> one ome 5 ☐ Reside	,	(Specify)
5	ing Ph	ion: T	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Ye	28b. Tim	e of 28c. Injur	y at </td <td>28d. Describe ho</td> <td></td> <td></td>	28d. Describe ho		
	to the floopital or Attending Physician: The I within 24 hours after death, within 24 hours after death, to the Funeral Director: After this certificate he completely filled in by the funeral director, page:	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury building, etc. (- At home, farm, Specify)	M 1 □	Yes 2□No	28f. Location (St City or Town	reet and Number n, State)	or Rural Route Number,
:	e Hospit 24 hours e Funera letely fille	edical C			amination and/o	eath occurred at the til or investigation, in my o				
	vithin To th	Me	29b. Signature and title of certifier	all	* -	29c. Licens	e number	2	9d. Date signed ((Month, Day, Year)
		2	30. Name and address/of gerson who cor	mpleted cause of deat	h (Item 232)	pe, Print)	6650		8-2	1-09
		7	margaret a ka	ises mo	8	88 lleme	rial D	THE &	Taklan	d. MD 21550
	Star Registra		31. Date filld (Month, Day, Year)	32. Registrar's	Signature	hardel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Sean William Sheridan

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		- For State Registrar			Certifica	ate of	Death				F	Reg. No.	4	UU	J E	011
Physiciar		1. Decedent's Name (First, Middl	ent's Name (First, Middle,Last) 2. Date of Death 3. Ti							3. Time of De	ath					
Medical Examin	er	Sear	n M. She	ridan							Month Nugust 1	1, 2009	Year		1225 hrs	S
		4a. Facility Name (if not institutio	on, give street an	d number)		41	c. City, Town	or Loc	cation of	Death			County of			
		Frederick Memorial He	ospital				Frederick					Fr	ederick			
Funeral	П	5. Social Security Number	6. Sex	7. Age (In yrs. last birt	thday)	If Under 1 \	_	If Under		. Date of B	irth(MM/D	D/YYYY)		place (State	or
Director	- 1	219-83-8945	1x M 2	F		Yrs.		ays 22	Hours	Min.	Feb.	20. 2	2009	Foreign Cour	ntry) Mary	_{71and}
		Usual Residence of Decedent					1 7 14	-2		1 1			.007		Hai	yland
anty O	Γ	10a. State 10b. County		10	c. City, Town	or Locatio	on	-						1	10d. Inside C	ity Limits
E though	_ I	Maryland Fre	derick		Freder	ick									1 X Yes	2 No
r Co C O	읈	10e. Street and Number				· · · · · · · · · · · · · · · · · · ·	10f. Zip Cod	е				10g. Citiz	en of Wh	at Count	ry?	
or 2	Director	1/11 D						1.70	•			***	1	a .		
ith th		2433 Dunmore Co		Decedent Ev	ver in H.S.	13 1//20	Decedent of	170		n2 (Specif	fy Yes or N		ited		ces an Indian, Bla	ack
death with the Maryland or items 23a or 28a-f sho	Funeral	1 X Never Married 2 M	arried Arme	ed Forces?	1		s, specify Cu						White		an maian, bit	ack,
		3 Widowed 4 Div	orced If Yes, Give	es 2 🗶 e Year	No	1	Yes 2 X	No e	enecify:				Specify:	Wh	ite	1
irs af	<u></u>	15. Decedent's Education (Spe	or Dates:		eted) 16a.		's Usual Occu			ind of work	done	1.1	ind of Bus			
72 hours after death with the Maryland 12 hours after death with the Maryland 12 saminer or items 23a or 28a-f sho	ᇵᅡ	Elementary/Secondary (0-12)		ge (1-4 or 5+			st of working					Ĩ			,	
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e file e file tal H ked o	- 1	James P. Morris	ı					10	01124	ney S	Shori	don				
ID 21; should be and Men 7 is mar		19a. Informant's Name/Relations)	19	b. Mailing	Address (S						y or Towr	, State,	Zip Code)	
MD d 2 sho fth and n 27 is		Matthew T. Sher	idan/ U	ncle	2	433 I	Ounmor	e Co	ourt	. Fre	deri	ck. N	larv1	and	21702	
2. E E E E		20a. Method of Disposition			20b. Place	of Disposit	tion (Name of	cemet	tery,	D	ate	20c. L	ocation -	City or T	own, State	
Baltimore, permit. Pages I ar Department of Hee Important: If ite			n 3 Remov	al from State	1	tory or oth										_
ti. P.	-	4 Donation 5 Other State 21. Signature of Funeral Service			Mt. U		t Ceme				2009	Fre	ederi	LCK,	Mary1	and
Baltimore permit. Pages I Department of F Important: If i	- 1	121116	X ////			Sta	auffer	Fur	nera	1 Hon	nes P	. A.				
Physician	4	23a. Part I. Enter the disease, or	complications/ti	nat caused th	e death. Do n	ot enter th	L Opos e mode of dv	na. su	m tow chasca	m Pik ordiac or re	spiratory a	reder	cick, ck. or hea	Ma	cvland proximat	21701
/Medical	- [failure. List only one cause	on each line		fant d								,		Between C	nset and
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0, be e	X L		AMEND													
8760, tificate by ng physic as the but	틝	IF FEMALE: 23b. Was decedent pregnant in the	ha	yes, outcome ive birth	of pregnancy		al death	3	Ectopic	prognancy			i. Date of Month			Year
OX 68 eath certi	<u>[</u>	past 12 months?		regnant at tir			er (Specify)	3	LCtopic	pregnancy	y		WICHT	D	ay	i eai
Box 6 death cer the attendi	Physicia	1 Yes 2 No 9 Uni	known 9u	Inknown		- Oil	lei (Opcony)									
P.O. B(that the de- ned by the		Part II. Other significant condit	tions contribut	ng to death b	out not resultin	g in the u	nderlying cau	se give	en in Par	rt I.	23e. Did	tobacco	use contri	bute to t	he cause of o	death?
ords, P.O. v requires that the s been signed by t should be detache	Completed by										1 🗆 Y	es 2	No 3	Proba	ably 4 L	Jnknown
cords law required bas been 2 should	iş.										24a. Wa				opsy findings	
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and inpute funeral director, page 2 should be detached for use as the burial - transition and the property of the p	<u> </u>	25. Was case referred to medica examiner?	Hospital:	1	0.4			_	Death (Check only				0"		
of Vi	라	1 ✓ Yes 2 No 27. Manner of Death			2 V ER/C					Nursing F		Reside		Other:		
n of ding Ph	6	1 V Natural	(Date of Injury Month, Day Yea 11, 2009	r) 200.	Time of Ir			at Work?		d. Describ	e now inju	iry occurr	eu		
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Spita spita hours y fille	١٥	4 Homicide 29a. Certifier	(Spe	cify) - Town	inouse					24	99 Dunm	ore Cour	t , t rede	rick , IV	10	
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ω	(Check only Certifying P	hysician: To the miner:On the ba	-	-											
To t To t	밁	29b Signature and title of certifie	and man	ner stated.	O 1		29c. Lic									1
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		July 2	aller	4/46	b			.C.M.	.C.			,				
	ſ	30. Name and address of person				10:										
		Assistant Medical			Street, Ba	altimore	, MD 2120)1								
Sta	ite	31. Date filed (Month, Day, Year)	2009	2 Registrar's	Signature	ha	11									
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			1- State of Ma	aryland / Dep <i>Ce</i>	artment of F ertificate of			Jiene _{leg. No.} 2009	28776
- ^	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Year	3. Time of Death
X	/Medic		Jean McKean Sollars		1		August	24 2009	5:15 A ^M
	Examin	er	4a. Facility Name (If not institution, give street and number)			r Location of Deatl	1	4c. County of Dea	ath
	Funeral		Oakland Manor 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday	Sykesv) If Under 1 Year		8. Date of Birth	Carroll	rthplace (State or Foreign
b	Director		1 M 2X F	94 Yrs.	Months Days	Hours Min.	(Month, Day March 3	r, Year) C	ountry) ryland
	D		Usual Residence of Decedent				march 3	0 1919 114	
	show	_	10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	Ba-f s	Director	MD Garrett	Kitzmil	-				1 X Yes 2 □ No
	with th	Dire	10e. Street and Number		10f. Zip Code		1	10g. Citizen of What C	
	sath v	eral	252 Main Street 11. Marital Status 12. Was Decedent E	Everinii e	21538	lionanio Origina (C	nacifu Vac ar Na	United St	
	ter de iner iner i	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Ves 2 ☒ N	lo	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerl	o Rican, etc.)	Black, Whi	
936	al', o	by	3 ☐ Widowed 4 █ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 💆 No	Specify:		Specify: W	hite
2-003	be filed within 72 hours after death with the Maryland Hylginen. 4 other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occup	ation	king	16b. Kind of Business	/Industry
2121	ithin and "I	nple	Elementary/Secondary (0-12) College (1-4or 5	+)	e kind of work done DO NOT use retired	danng most of wor d)	Killy		
2	led w lygier her th	Ö	12	RN	/ Staff			Hospital	
and	e d stal	Be	17. Father's Name (First, Middle, Last)					Maiden Surname)	
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	iges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		Nancy Dudash, Niece		0 LaSalle				
ē,	es 1 and 3 of Health fitem 27 r other tra		20a. Method of Disposition	20b. Place of Disp		1	Date	20c. Location - City o	
Ë	Pages nent of int; If its iry or o		1 ☐ Burial 2 [XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	1	ind Cremat	· i	5/2009	Cumberland	. MD
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licensee		2 Name and Addre	es of Facility			ŵ, ,
m 	8 8 E 6 8		Katherine Surither		21 N. Se	cond St.	, Oaklan	Home, P.A d, MD 2155	Ö
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory arr	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	clerini	Caxenov	rascylo	XX DIS	ease	Onset and Death
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o.	ie dea the at hed fo	Physician/M	1 ☐ Yes 2 ☐ NO 4 ☐ Pregnant at 9 ☐ Unknown	time of death 5[Other (specify)			Month	Day Year
J.	hat the		Part II. Other significant conditions contributing to death but	t not resulting in the u	ınderlyina cause aiv	en in Part I	23e Did to	bacco use contribute t	o the cause of death?
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יס ר	ng Ph ter th neral	n: T	27. Manner of Death 28a. Date of Injur 1 ☐ Matural 5 ☐ Pending (Month, Day		of 28c. Injur Worl	y at		ow injury occurred	3011)/14/36/14/44/4
0	endineath.	atic	2 Accident investigation		I	Yes 2 □ No			
UIVISION	or Att fter de Direct in by	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of inju building, etc	ry - At home, farm, st . <i>(Specify)</i>	reet, factory, office		28f. Location (Si City or Town	treet and Number or F n, State)	Rural Route Number,
_	pltal ours a leral I		29a. Certifier 1 Certifying Physician: To the best of	f my knowledge, deat	th accurred at the fir	mo data and place	and due to the o	and manner	o stated
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral.	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or in	nvestigation, in my o	ppinion, death occu	rred at the time, o	late and place, and du	e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. Licens			9d. Date signed (Mor	
)			· Carl		D43	725		812410	19
		,	30 Name and address of person who completed cause of de		Print) 7	0	1	· · · / · · · ^	1D 2 /107
			31. Date filed (Month, Day, Year) 32. Registra	19, Rid r's Signature	de 100	ad v	vertmi	nister '	1021157
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Avis Bondena Schultz 4:30 p M August 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 1, 1 Birthplace (State or Foreign Country) **Funeral** 219-14-9194 1 □ M 2 🔀 84 Sept. **Director** Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show d other than "natural", or items 23a or 28a-f sho event, the Modical Evantion of Frederick Maryland Frederick 1 □Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 8122 Rocky Springs Road 21702 death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces? filed within 72 hours after 1 □Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo \$ Specify Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Factory Seamstress 12 marked other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental HImportant: If Item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Henry Kepler Catherine Remsburg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code David K. Schultz, Jr., Husband 8122 Rocky Springs Road, Frederick, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Sept. 4, 2009 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Keeney and Basford PA Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. 106 East Church St., Frederick, MD Approximate Interval Between Onset and Death Immediate Cause (Final Physician Afanc ho DO /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for as a no issaulment of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical aftending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a ☐Yes 2 No s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>6</u> 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 □Yes 2 No 1 ☐ Yes 2 No this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one)

State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 DL

65 C The 31. Date filed (Month, Day,

title of certifier

Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hon son

29b. Signature and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mark William Timms State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day August 30, 2009 Medical Examiner 0953 hrs Mark William Timms 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3936 Deer Park Court Havre de Grace Harford 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 6. Sex 7. Age (In yrs. last birthday) Foreian Months Days Hours Director Country) MD 214-74-6393 Feb. 25,1959 1XXM 2 F 50 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. 1 Yes 2 X No MD Harford Havre de Grace hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4028 Chapel Rd. 21078 U.S.A Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, the Medical Examiner must be Armed Forces? White, etc. Never Married 2 Married Yes 2 X No 4 X Divorced If Yes, Give Year White Yes 2 No specify: Specify: ě 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) permit Pages 1 and 2 should be filed within 72 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r College (1-4 or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, Be George William Timms JoAnn McIntire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Q</u> JoAnn Phillips (Mother) Havre de Grace, MD 4028 Chapel Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Baltimore 2 Cremation 3 Removal from State Burial West Chester, PA A. Ferris & Co. 9/2/09 Other Specify Donation, 21. Sign 🌲 Funeral Ser e 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen MD 21001_3399

Issue, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease aAlcohol and oxycodone intoxication xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a, PII, 2/, 28a-f, permE, g895 9/10/09 TT attending physician or use as the burial -XUNPENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Orophanyngeal cancer Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes No 25. Was case referred to medical director, 26.Place of Death (Check only one) **Division of Vital** Be Hospital: Other-After this ို 1 Yes Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? Certification: Natural Yes 2 XNo lunk within 24 hours after death. To the Funeral Director: Pending the FD 8/30/09 Fd 9:14 am 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Boute Number City or Town, State) 3936 Deer Park Ct Havre de Grace, MD 6 X Could not be Suicide residence (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and tive of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 31, 2009 Massel 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** OCME

09-06/68

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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Physician
/Medical
Examiner

For State Registra

Funeral Director

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ittle event 18-12-12

Baltimore, Mary	permit. Pages 1 and 2 shoi Department of Health and b Important: If Item 27 is ma any Injury or other treume once.		19a. informant's Name/Relationship (Type. Print) MICHAEL TERRY HUSBAND 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	I			
Baltir	permit. P Departme Importan any Injur		4 Donation 5 Other (Specify) 21 Signature of Funeral Service License	7)	22. Name	and Address of Facility 2th STREET	
8760,	ate be executed /Medical Examiner /Medical Examiner /Itansit /Itan	lical Examiner	23/ Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a domination of the condition of the cause. Enter Underlying Cause (Disease or injury that initiated events of the cause. Enter Underlying Cause (Disease or injury that initiated events of the cause of the cause. Enter Underlying Cause (Disease or injury that initiated events of the cause of the	consequ	cancer of):	ode of dying, such as o	cardiac or r
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but Tachy Cardia Pleural effucions	Fetal	death 3□Ectopic eath 5□Other		
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: . completely filled in by the f	Medical Certification: To	29a. Certifier (Check only one) Certifying Physician: To the best of Medical Examiner: On the basis of eand manner state	examinat	tion and/or investigati	ion, in my opinion, dea	d place, an
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CA	Sta Registr		30. Name and address of person who completed cause of dea ALIRAHIMIAN MID 10 31. Date filed (Month Day) (Paris) 32. Registran	040	3 Hosi	vital Di	SVE
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1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 20,2009 12:45 P M TERRY SARAH 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) PRINCE GEORGES CLINTON SOUTHERN MARYLAND HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day. 9. Birthplace (State or Foreign 7. Age *(lr* **54** 5. Social Security Number (In yrs. last birthday, Days 1 □ M 2√ F DC 577 74 4333 Yrs 02-06-1955 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director PRINCE GEORGES TEMPLE HILLS MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 5715 MIDDLETON LANE 20748 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ▼No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SELF **EMPLOYED** DOMESTIC ENGINEER 12th 2years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FLOYD LESSIE WILLIE MOATES ೭ Route Number, City or Town, State, Zip Code) LE HILLS, MARYLAND 20748 20c. Location - City or Town, State 2009 LAUREL, MARYLAND Twashingsof, bc 20017 LLC Approximate Interval Between Onset and Death espiratory arrest, 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 1 ☐ Yes 2 No Check only one) 5 ☐ Residence 6 ☐ Other (Specify) 3d. Describe how injury occurred Bf. Location (Street and Number or Rural Route Number, City or Town, State) nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) CLINTO MD20731

State of Maryland / Department of Health and Mental Hygiene []

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician Aug 30, 2009 Pearl 2255 Juanita Thompson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frostburg Village Nursing Home Frostburg Allegany 8. Date of Birth (Month, Day, Year) Apr 17, 1930 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 6. Sex **Funeral** Days Hours 1 M 2 K 217-28-8816 Yrs. 79 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral', or items 23s or 28e-f show Examiner must be notified at MD Allegany Cumberland 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14207 Canal Ferry Road 21502 USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s eny injury or other traumatic event, the Mental Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Midowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

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16a. De 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) G.C. Murphy Co. clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William H. Walbert, Jr. Pearl (Filer) Walbert 2 19a. Informant's Name/Relationship (Type, Print) William Walbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13802 Brant Avenue Cresaptown MD 21502 brother 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Hillcrest Memorial Park 9/2/2009 MD Cumberland 4 □ Donation \$ □ Other (Specify) 21. Signature of Fureral Service Licentee 22. Nam Scarpeili Füneral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART BAT WERF **Physician** CONCESTIVE /Medical Examiner CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed signed by the attending physicien and deed betached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by UNG been signal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2\\\\ 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this Director: After the in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funerel C
completely filled 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Heroun D 26907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 925 SIDHU, M.D BISHOP WALSH RD. CUMBERITAND MD 2150 EP 09 32. Registrar's Signature 31. Date filed (Month, Day, State Ckneera Registrar TORKE

DIL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. Amend I tem 26 per phys. 5895 9/14/09 and State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** p^{M} 2009 1:14 8 16 Shawn Troy Williams /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wicomico 134-A First
5. Social Security Number Salisbury
If Under 1 Year | If Under 24 Hrs. | Street 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 € M 2 □ F 30 Director 212-94-0454 9 - 2 - 1978MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show s 23a or 28a-f show 1 Tyres 2 □ No Director MD Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 134-A First Street 21801 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 11. Marital Status Injury or other traumatic event, the Medical Examination 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Maryland 21215-0036 1 ☐Yes 21☑No Specify: Specify: ģ Department of Health and Mental Hygiene.
Important: If tem 27 is marked other than "natural", any injury or other traumant necessary. 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Red Lobster Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Paulette E. Powell Layton H. Williams, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2180 MD1008 Fairground Dr, Apt 10, Salisbury, Paulette Powell/Mother Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Crematory 18-19-2009 Dover, DE Direct 22. Name and Address of Facility 917 W. Isabella St Signature of Funeral Service Licensee Bennie Smith Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that cause if the death. Do not enter the monor of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on, act yine. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the repring Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of): and burial-trar Due to (or as a consequence of): Box 68760. attending physician pe Physician/Medical the nse If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Month Year in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No signed by the a Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. b 2 No 3 Probably 4 Unknown 1 🗆 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home XX Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completely filled in by the funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation atural 1 □Yes 2 □ No Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29b. Signature and title of cortifier 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person e of death (Item 23a) (Type, Print) South Division St., Ste 301, Salisbury m.D. 1340 nnan 31. Date filed (Month, Pay, Year) 32. Registrar's Signature State Registrar

-4-16

William

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Williams **Physician** Beverly 50004 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner legiona If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Months 225-54-8586 1 □ M 2 🔀 F 68 11/29/1940 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examiner must be rediffed at once. 1 ☐ Yes 2X No Wicomico Hebron Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 21830 25622 Rewastico Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc. 1 ☐Yes 2x If Yes, Give Year or Dates: 1 Never Married 2 Married laltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify: þ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Virginia Department of Elementary/Secondary (0-12) College (1-4or 5+) Social Services financial manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Coleman William Seay ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25622 Rewastico Rd., Hebron, MD 21830 19a. Informant's Name/Relationship (Type. Print) Gregory Williams/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Salisbury Crematory 8/19/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address Tuneral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Closhidun Hule disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consecuence of The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 12 ☐ No 1 ☐ Yes Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1☐Inpatient 2☐ER/Outpatient 3☐DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 🔾 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 63199 09 30. Name and addre ess of person who completed cause of death (Item 23a) (Type, Print) SAUSBURY MD SHORE EASTERN 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day **Physician** 223 ennes 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min 07/21/1942 Year) Months Days Hours 1 **K**M 2 □ F Mary Tand 218-38-5093 67 Yrs Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at Calvert Prince Frederick 1 ☐ Yes 2 🕅 No Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 Pages 1 and 2 should be filed within 72 hours after death with United States 20678 320 German Chapel Road items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. Specify: white þ 3 ☐ Widowed 4 ☐ Divorced natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Maone. Elementary/Secondary (0-12) 12 College (1-4or 5+) electrician construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milburn H. Wood Doris Buck 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 763 Prince Frederick Maryland 20678 Billie Jo Wood-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug 27 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria Virginia Metropolitan Funeral Service 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Island Rd. Port Republic MD 20676 BR CX 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** do pirator Due to (or s a consequence of): /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequent of Examiner the Hospital or Attending Physiclan: The law requires that the death certificate be executed COPD Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) □Yes the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 1☐ Yes 2K No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🌿 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year)

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State Registrar

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31. Date filed (Month, Day,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ORIGINAL

D006178

Prince Frederick MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Kathleen Webb Short Watson 08:25 A August 22 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Wicomico Salisbury Wicomico Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days 9/19/1928 Hours 80 MD 1 M 2 XF 218-24-7254 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 🛣 No Worcester Girdletree MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21829 5507 Onley Rd. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🛣 No Specify: white 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillie Belle Timmons William Henry Webb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5605 Taylor Rd., Snow Hill, MD 21863 Gary Wayne Short / son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 □ Cremation 3 ☐ Removal from State Springhill Cemetery 8/26/2009 Girdletree, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service L 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore,

111

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner and Physician/Medical attending I for use as ģ Completed certificate Be P within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of Certification:

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Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury	b					
hat initiated events resulting in death) Last	c					
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 9 ☐ Unknown	23d. Date of delivery Month Day Year				
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ hknown				
		24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 700 1 Yes 2 700				
25. Was case referred to medical	26. Place of D	eath (Check only one)				
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manuer of Death 1√ Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred				
3 Suicide 6 Could not determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier 1 Certifying F	Physician: To the best of my knowledge, death occurred at the time, date and pla aminer: On the basis of examination and/or investigation, in my opinion, death or	ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)				

BA3

the Hospital or Attending Physician:

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

614 Eastern Shore Dr., Salisbury, MD 21804 Maesha Thimmarayappa, MD

AUG 2 5 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended #26, nls, per phy., 08/27/09, Allegany Co. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician Wilt 25, 6:45 A. Calvin 2009 Lester August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia 7390 Sweet Clover If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 X M 2 □ F 84 Yrs Director 01/26/1925 Maryland 218-16-4562 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Wedfool Evandors, but be nottlined at 1 □Yes 2 🙀 No MD Allegany Cumberland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with USA 21502 11612 Olive Avenue Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? XYes 2 Yes, Give 2□No 1943-1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: \$ 3 ☑ Widowed 4 ☐ Divorced 1946 White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tire and Rubber Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be n and Mental P and 2 should be Lee Wilt Bertha Mav Delbert Augusta ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7390 Sweet Clover, Columbia, MD Debra Wilt-Selman / Daughter of Health item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot Pages 1 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Cumberland Crematory | 08/26/2009 | Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Tome, F.A. signature of Funeral Service License 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TEN MONTHS **Physician** a ESOPHAGEAL CANCER STAGE FOUR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if at y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical use as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 \(\subseteq \text{ Ectopic pregnancy} \) Month Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No Ö the 9 Unknown 9 Unknown à ۵. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Yes 2 No 3 Probably 4 Unknown ANEMIA, MALNUTRITION Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law certificate has page 2 autopsy performed? 1 □Yes 2 No 1 ☐ Yes 2 🛣 No Division of Vital Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 3 Residence 6 Other (Specify) Naughter 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death within 24 hours after death.

To the Funeral Director: Afte completely filled in by the funeral process. 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30573 8-25-09 MA 10+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nRs 10710 CHARTER DRIVE, SUITE GO20, COLUMBIA, MD 21044 MINFORD, M.D., 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 21, 2009 0503A M WILLIAMS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 T F JUNE 23. 1949 WASHINGTON, DC 60 214-52-6377 Director Usual Residence of Decedent ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I'M Modical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 1XYes 2 No Directo MONTGOMERY SILVER SPRING MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 1131 UNIVERSITY BLVD WEST #817 20902 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: \$ 3 ☐ Widowed 4 🏻 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE COMPUTER SYSTEM ANALYST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ATHELSTEIN FISHER LEMROY COLEMAN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2811 MUSCLEWOOD COURT LANHAM, MD 20706 LANCE WILLIAMS/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 permit. Page Department o Important: If i any injury or 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 18-25 -2009 RIVERDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL ROME 21. Signature of Funeral Service Licens 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed HYPOTENSION burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 5 Other (specify) ☐Yes ZXXNo 9 I Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 END STAGE RENAL DISEASE 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed? 1 □ Yes 2 🖾 No Hospital or Attending Physician: The certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie, 8/21/2009 D68150 ress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add NEJIB SIRA, MD 1500 FOREST GLEN ROAD SILVER SPRING, MD 20910 31. Date filed (Month, Day, Year, State AUG 2 5 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State AMENDED 08/27/09 PER FH #4 Certificate of Death KB FCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear Donna Sue Wilson 8 20 2009 5:14 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1126 Rosemont Drive Knoxville Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 4/11/ Birthplace (State or Foreign Country) 1□M 2₹F Months Days Hours Frederick MD 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Frederick Knoxville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1126 Rosemont Drive 21758 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Paralegal Law Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Douglas Wetnight Mary Frances Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D Wilson, 36 Skyline Ct, Keedysville MD 21756 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gand. 8/25/2009 Frederick MD 21. Signature uneral service License 22. Name and Address of Facility Bantara A Williams John T Williams Funeral Home, Brunswick MD 21716 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (mo years

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Completed by Funeral

Be ၉ MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: It item 27 is marked other than "netural", or items 23a or 28e-1 show any injury or other traumatic event, the Madical Examinat the Intiffied at once.

Saltimore, Maryland 21215-0036

burial-trans

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

ucal Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b						
ysicializme	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year					
completed by ri	Part II. Other significant conditions of		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unkno 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No					
25	25. Was case referred to medical examiner?	26. Place of Death (Check only one)						
	1 ☐ Yes 2 W No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5X Residence 6 □Other (Specify)					
ation;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of linjury 28c. Injury at Work? M 1 Yes 2 No	Describe how injury occurred					
Cermic	3 Suicide 6 Could not be determined	286. Place of injury - At nome, farm, street, factory, office 201.	Location (Street and Number or Rural Route Number, City or Town, State)					
ııcaı	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medicel Exem	ysicien: To the best of my knowledge, death occurred at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the cause(s) and manner as stated. t the time, date and place, and due to the cause(s)					

29c. License number

22037

29d. Date signed (Month, Day, Year)

State Registrar and

29b. Signature and title of certifier

NINTU 610 32/Registrar's Signature pares

and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

within 24 hours a To the Funerel (completely

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

1. Decodern's Name (First, Middle, Last) 2. Desire of Death 2. Des		1 - State Registrar		. y . a	Department of F Certificate of			ene g. No. 2010	237	
Scotal Security without of the season of the			ast)						3. Time of Deat	
## Facility Name (if not healthfur, give sheet and number) ## Cost May 2 Mary 10		49		helm			Month	Day Year		
RestHump Security				10///	4b. City. Town, o		rug ust			
District Residence of Decedent 10c. City, Town or Location 1	eral	Frostburg Villag 5. Social Security Mimber 96.	Sex 7. Age		thday) If Under 1 Year	Hours Min	(Month Day	Allegar Year) 9. Bir	thplace (State or For	
Part	40			10c. City Town	or Location				10d. Inside City Lin	
Part	ō								1 □ Yes 2 X	
Part	irec		.9	- / // - /				10g. Citizen of What Country?		
Part	a D	1195 Old FA	1054 burg 60	ond	215	32		U.S.A.		
Secure that Secure that	ner		12. Was Decedent E	ver in U.S.	13. Was Decedent of H	Hispanic Origin? (Spec	cify Yes or No-			
Part	교		1 Yes 2 No	0			iican, eic.)		e, etc.	
23. Part i, Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Cause of heart failure. List only one cause on each line. Interval Between Cause of heart failure. List only one cause on each line. Due to (or as a consequence of): Due to (or as a co	d b	3 Widowed 4 🛭 Divorced	Year or Dates:		To les Zyano	Зресну.		Specify: W	hite	
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Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director,

29a. Certifier 1

29b. Signature and title of certifier

Russell Alexander MD.

31. Date filed (Month, Day, Year)

Medical

State

Registra DHMH 11 Fee 1/2001 **OCME 2006**

32 Registrar's Signature

1

Assistant Medical Examiner

and manner stated

30. Name and address of person who completed use of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

OCME

2035 hrs

10d. Inside City Limits

1 Yes 2 X No

Approximate Interval

Between Onset and

Death

Year

2 No

Day

29d. Date signed (Month, Day, Year)

August 19, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) tomber Zear 2009 **Physician** Daymien Adams /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital Baltimore City Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Aug. 8, 2009 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. **Funeral** Months 1 X M 2 🗆 F 0 n/a MD 26 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show the Medical Examiner must be notified at 1 Yes 2 No Director MD Baltimore Dundalk 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ö 9 Eastship Road items 23a 21222 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 21215-0036 ō American 1 Yes 2 No þ 3 Widowed 4 Divorced Year or Dates 'natural", 16b. Kind of Business/ nous rv Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4 or 5+) n/a n/a n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland other traumatic event, Be and Mental ment of Health and Mental Franklin Adams Stephanie Helmick 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Helmick /grandmother 9 Eastship Road Dundalk MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Sacred Heart of 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If it and any Injury or of orce. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Jesus 9/9/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee pormit. 22. Name and Address of Facility 300 Mace Ave. Balto. MD 23a. Part 1. Enter the disease, or complications that caused. Connelly Funeral Home of Essex fee death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy Month Day Year filled in by the funeral director, page 2 should be detached for in the past 12 months? Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) မ this Date of Injury (Month, Day Year) . Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 Tes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director; 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation in my opinion death. Hospital within 24 hours To the Funeral 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

SEP 1 0 2009

DHMH 17 Rev 1/2001

of person who completed cause of death (Item 23a) (Type, Print)

D6956

600 North Wolfe St, Baltimore, MD, 21287

Examiner RMSTRONG o GEORGE Hospital or Attending Physician; The Division of Vital

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be

2

Funeral

Director

filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be recitled at

Physician /Medical

sign I be

disease or condition resulting in death)	a. THEUMU Due to (or as a conseq					6 Days
Sequentially list conditions, from the day of the cause. Enter Underlying Cause, (Disease or Injury	b. Myo CA	RDIAL Suence of J.	INFARCTIO			Day
Cause (Disease or injury that initiated events resulting in death) Last	c. CORONA Due to (or as a conseq	RYART	ERY DISE	4SE	-	20 years
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of 9 Unknown	al death 3□Ectopi	c pregnancy (specify)		23d. Date of de Month	livery Day Ye ar
Part II. Other significant conditions of	contributing to death but not res	ulting in the underlyin	g cause given in Part I.			o the cause of death?
				24a. Was an autopsy performed?	prior to death?	utopsy findings availabl completion of cause of s 2 No
25. Was case referred to medical			26. Place of De	eath (Check only one)		
examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 ☑ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 In Nursing	Home 5 ☐ Residence	6 ☐ Other (Spe	ecify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in		
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route of City or Town, State)					ural Route Number,
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occur ation and/or investigat	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner a and place, and du	as stated. e to the cause(s)
29b. Signature and title of certifier			29c. License number	29d.	Date signed (Mon	th, Day, Year)
A. INDU	KURI MD		P2406	o Sep	TEHBER	04 2009

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu

900 CATON AYE, BALTIMORE, MD 21229

09-06863 Phillip Angel

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certi	ficate of l	Death			Reg. No.	200	0 2070
Physicia	ın/	Decedent's Name (First, Middle,Last		T21	J A	1 7		2. Date of De Month	Day Der 2, 2009		3Fime of Death / - 0938 hrs
edical Exami	ier	4a. Facility Name (if not institution, given	Phillip	FIMOO		L, Jr.	ocation of I			ounty of Death	
		University Hospital	e street and manipery			Baltimore				N/A	
Funeral		Social Security Number 6. S	ex 7. Age	e (In yrs. last	t birthday)	If Under 1 Year	If Under 2		3irth(MM/DD/	YYYY) 9. Birth Foreign	
Director	- 1	215 80 8151 12	X M 2☐F	47	Yrs.	Months Days	Hours	Min. 09/	16/196		ntry) Maryland
*	İ	Usual Residence of Decedent		10 0" T							10d. Inside City Limits
w an	ı	10a. State 10b. County	Amunda1	,	own or Locatio						1 Yes 2 X No
yland a-f sho	흱	Maryland Anne 10e. Street and Number	Arundel	G	len Bu	10f, Zip Code			10g. Citizen	of What Count	
ith the Maryland 23a or 28a-f show any notified at once.	Director	402 Milton Ave	n 110			•	060		_	.S.A.	
with the s 23a e noti		11. Marital Status	12. Was Decedent	Ever in U.S.	. 13. Was	Decedent of His	panic Origin	n? (Specify Yes or I		Race - Americ	an Indian, Black,
death w or items must be	Funeral	1 Never Married 2 Marrie	d Armed Forces?	X No	If Ye	s, specify Cuban	, Mexican, F	Puerto Rican, etc.)		White, etc.	
after (by F		d If Yes, Give Year or Dates:			Yes 2 X No				ecify: Whi	
hours natur Exam	pa	15. Decedent's Education (Specify of	, , ,		16a. Decedent during mo	s Usual Occupat st of working life.	ion (Give kir DO NOT u	nd of work done se retired)	16b. Kind	d of Business/In	dustry
336 thin 72 se. than "	plet	Elementary/Secondary (0-12) 10th	College (1-4 or	5+)	Lost	Preven	tion A	Assoc.	W.	almart	
5-00 led with Hygiene other i	Completed	17. Father's Name (First, Middle, Las	t)				18.Mother's	Name (First, Middle	e, Maiden Sur	rname)	
21 be fi	Be (Philip E	. Ang				Viola G			
ord N big	T ₀	19a. Informant's Name/Relationship				Address (Stree		er or Rural Route N			Zip Code) Land 21060
두 모든 모루		Viola G. Angel 20a Method of Disposition	/ Mother	20b Pl		tion (Name of cer		Date		cation - City or	
		1 X Burial 2 Cremation 3	Removal from St	ate cr	ematory or oth	er place)		00/08/200	Marr	riottev	ille, MD.
Baltimo permit. Page Department of Important: injury or oth		4 Donation 5 Other Special 21. Signature of Funeral Service Lice		Ure	1	Mem. Pa		Gonce Fu			
Balti permit. Departn Imports)	71. 9	romerce	whi	40	01 Ritch	nie Hi	ghway Ba	altimor	re, Mar	yland 21225
Physician		23 art I. Enter the disease, or confailure. List only one cause on		the death.	Do not enter th	e mode of dying,	such as ca	rdiac or respiratory	arrest, shock,	, or heart	Approximate Interval Between Onset and
/Medical taminer	i d	Immediate Cause (Final disease	Subarachnoid a			Hemorrhage					Death
		or condition resulting in death)	Due to (or as a cons			m					
	e	if any, leading to immediate	Due to (or as a cons								
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cons	equence of)							
scuted and transit		events resulting in death) Last	d.								
exe	Medical	UNPENDED	X AMENDED #1	as no	ted pe	r ME G89	95 9/1	5/09 TT			
		IF FEMALE:	23c. If yes, outco	me of pregn	ancy					Date of delivery	
Ox 68 ath certifi attending or use as	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a	it time of dea	th =	tal death 3 ner (Specify)	Ectopic	pregnancy	M	lonth [Day Year
Box te death c the atten	Physician	1 Yes 2 No 9 Unknow			0 00	let (opcomy)					
that the	by Pł	Part II. Other significant condition	contributing to dea	th but not re	sulting in the u	inderlying cause	given in Par				the cause of death? bably 4 Unknown
ords, P.C. v requires that s been signed is	ed b							24a. W			utopsy findings available
ord aw req as bee 2 shou	Completed							a	utopsy erformed?		completion of cause of
tal Rec	Son							1 🗸 Y	es 2 No	1 🗸 Ye	es 2 No
Vital Rec ysician: The his certificate director, page	Be B	25. Was case referred to medical examiner?	Hospital:	iont 2 M	ER/Outpatient		Other	Check only one) Nursing Home 5	Residence	ce 6 Othe	
of Vital Records, ling Physician: The law require. After this certificate has been si funeral director, page 2 should b	<u>유</u>	1 Yes 2 No 27. Manner of Death	28a. Date of In	jury	28b. Time of I		ury at Work		ibe how injury		
OD C ending ath. or: Af	tion	1 Natural 5 Pending		,Year)		1	Yes 2	No			
Division tal or Attendi rs after death. al Director: /	ertification:	2 Accident Investig 3 Suicide 6 Could n	28e Place of I	Injury - At ho	me, farm, stre	et, factory, office	building, etc		on (Street and	d Number or Re	ural Route Number, City
Divi spital or sours after neral Dir	Cert	4 Homicide determine	(0,000)/		_						
Division of Vital Records, P.O. Box 68: To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. The Funeral Directors. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as 1	edical	29a. Certifier 1 Certifying Physone) 2 Medical Examin	ician: To the best of r	my knowledg	ge, death occur nd/or investiga	rred at the time, of	date and pla in, death oc	ice, and due to the curred at the time, o	cause(s) and tate and place	manner as stat e, and due to the	ted. ne cause(s)
To t with To t	Med	29b. Signature and title of certifier	and manner stated	d.			se number				onth, Day, Year)
	-	MI. R.	(/ M)			0.0	.M.E.		Septe	ember 3, 20	009
		30. Nome and address of person wh	o completed cause of	death (Item	23a)						
H			Assistant Medica	al Examir	ner 111 F	Penn Street,	Baltimore	e, MD 21201			
S Regis		31. Date filed (Month, Day, Year)	- 10	rar's Signat	re bar	es!					
17-7-1	415		ALCOHOL:								

OCME

09-06868		Please Type or Print in Black Indelible In		egible.
Erma Butler		State of Maryland / Department of Certificate of	Death	2009 287
Physicia	an/	Registrar 1. Decedent's Name (First, Middle Last)	2. Date of De	
Medical Exami	ner	Erma Butler		per 2, 2009 Year 1703 hrs
To-		4a. Facility Name (if not institution, give street and number) 4419 Manorview Road	o. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		hirth (MM/DD/YYYY) 9. Birthplace (State or Fore
Funeral Director		213-76-2299 1 M 2 A 10 Yrs.	Months Days Hours Min.	Country)
		Usual Residence of Decedent		
W an		10a. State 10b. County 10c. City, Town or Location	n , (10d. Inside City Limit
yland n-f sh	tor	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
ne Man	Director	4419 Manorview Rd	21220	1150
r death with the Maryland nr items 23a nr 28a-f show any must be mutified at once.	rai		Decedent of Hispanic Origin? (Specify Yes or N	lo- 14. Race - American Indian, Black,
leath y	Funeral		s, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
after o	by F		Yes 2 No specify:	Specify: Black
2 hours after "matural",		during mo	s Usual Occupation (Give kind of work done st of working life, DO NOT use retired)	16b. Kind of Business/Industry
36 in 72 in dical	plet	Elementary/Secondary (0-12) College (1-4 or 5+)	unknown	unknown
21215-0036 hould be filed within 77 hold Mental Hygiene. is marked nither than site event, the Medical	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle,	
21215 buld be file Mental H marked 1	Be (unknown	Unkr	nown
Baltimore, MD 21215-0036 Dermit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked auther than "natural", ur items 23a nr 28a-f she injury or other traumatic event, the Medical Examiner must be muffred at once	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or Rural Route Nu	umber, City or Town, State, Zip Code)
ore, MD st and 2 sho of Health and fitem 27 is	П	20a. Method of Disposition— 20b. Place of Disposit	ion (Name of cemetery. Date	20c. Location - City or Town, State
Baltimore, bernit. Pages I an Department of Hea Important: If ite njury or other tr		1 Burial 2 Cremation 3 Removal from State crematory or other		10 11 200
Baltimo permit. Page Department of Important: injury or ott		4 Donation 5 Other Specify: 11 12 No.	rematory 9/10/09	Baltimore, In
Baltil permit. Departm Imports injury o		Brok & Howell A. 40	or Liberty Height	5 Am. Bato MD200
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	e mode of dying, such as cardiac or respiratory an	1 2
/Medical Examiner	1	Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Dise	ase	Death
		or condition resulting in death) Due to (or as a consequence of):		
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
_	를	cause. Enter Underlying Cause (Disease or injury that initiated		
nted d ansit	Exami	events resulting in death) Last		
execuian an	ical	UNPENDED AMENDED		
760, zate be physic he burn	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Box 68760, death certificate be execut the attending physician and effor use as the burial - tra	Physician/Medical	past 12 months?	al death 3 Ectopic pregnancy	Month Day Year
Box e death the atter	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Othe	er (Specify)	
ords, P.O. B w requires that the d s been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
Division of Vital Records, P.O. tal in Attending Physician: The law requires that the ray after death. al Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detach	d by		1Ye	es 2 No 3 Probably 4 🗹 Unknown
Cords Iaw requests been as peer	Completed		24a. Was	
Reco	E			ormed? death? 2 ✓ No 1 Yes 2 No
ital Recions: The scrifficate rector, page	Be	25. Was case referred to medical examiner?	26.Place of Death (Check only one)	
f Vid	리	1 ✓ Yes 2 No Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of Injury		Residence 6 Other: Scene
on of anding Ph.	Ö	1 Natural 5 Pending (Month, Day, Year)	1 Yes 2 No	Thow injury occurred
rision r Attenc er death rector:	icat	2 Accident Investigation 28e. Place of Injury - At home, farm, street		(Street and Number or Rural Route Number, Cit
Divis pital nr At ours after d teral Direc	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town,	
Hosp 24 hot Funet		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre (Check only	ed at the time, date and place, and due to the cau	use(s) and manner as stated.
Division of Vital Records, P.O. Box 68760, The the Hospital ar Attending Physician: The law requires that the death certificate be execut within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.		e and place, and due to the cause(s)
	ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		Carel Hallon	O.C.M.E.	September 3, 2009
		30. Name and address of person who completed cause of death (Item 23a)		

State 31 Date filed (Month, Day, Year)
Registrar OCME 2006

OCME

32. Peģistrar's Signature

Carol Allan, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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tal Hygiene.

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Health tem 27 i

Department of P Important: If ite any injury or ot once.

Exeminer must be notified at

other traumatic event, the Mudical

Funeral Director

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

Peral Director: After this certificate has been signed by the attending physician and filled in by the funetal director, page 2 should be detached for use as the burlansit miss.

of Vital Records,

Division

within 24 hours a

Physician/Medical Examiner 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier ix Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier D25575

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 South Greene St., Univ. of Maryland, Baltimere SUSAN D. WOLFSTHAY MD

31. Date filed (Month, Day, Year) State Registrar

32. Registrar's Signature Jacks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 146 M Month Year **Physician** Ac. County of Death BIVENS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 1 Months MAY Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ō or items 23a ON 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced 16b. Kind of Business/In justry "natural", 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trailmeats. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 0 ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/3 22 19a. Informant's Name/Relationship (Type. Print) 20a. Method of Disposition DUNDALK Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State SIEPT 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final 21224 Immediate Cause (Final disease or condition resulting in death) ARDIOMYOPATH **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed after death. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Pres 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 □ Yes aΕ 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Tes 2 🗌 No 2 Accident 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D56466

Registrar

Dundalk

Ave Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHATA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Vear Month **Physician** M. Treva Brown Sept 2009 5:00 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Kingsville 701 Pleasant Hills Road Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Davs 82 227-24-3993 Director Oct. 22,1926 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Director Dundalk Maryland Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 United States 805 Wise Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene Important: If item 27 Is marked other than any injury or other traumatic event, the Ms once. Elementary/Secondary (0-12) College (1-4or 5+) A & P Supermarkets 10 Years Meat Cutter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Katherine Clems Hubert Dofflemeyer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 701 Pleasant Hill Road Kingsville, MD 21087 Patricia A. Pelekakis (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9/9/2009 Baltimore, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fur e | Service Livinse 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. who 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1/2 years Physician Nonsmall Cell Luns /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Cancer 1 Yes 2 No 3 Probably 4 Unknown Completed Hyper tension 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Daughter's Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0

DHMH 17 Rev 1/2001

State

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

6730 Holsbird

32. Registrar's Stgnature

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31. Date filed (Month, Day, Year)

SEP 1 0 2009

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MD 21222

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 00a M 2009 4ugust /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner atonsvi Home YUrs 100 8. Date of Birth (Month, Day, Y June 13, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex . Age In yrs. last birthday Social Security Numbe **Funeral** Days Hours 1**X** M 2□ F Ĩ945 Yrs Maryland 212-44-9548 64 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 USA 701 Edmondson Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental if Health and Menta Harry T. Bark Sr Irene J. Szymanski 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda Markiewicz/sister 709 S. Potomac Street Baltimore, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Nother (Specify) in state 4 ☐ Donation Signature of Funeral Servi 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Ronald nn 21201 Baltimore, MD 23a. Part1. It ter the diseast or confections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death LULTIPLE Immediate Caus Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immodute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of): Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician a Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month for 4□Pregnant at time of death 5 Other (specify) the 9∏Unknow⊓ 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Uhrknown 1 Tyes Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of death?
1 ☐ Yes 2 ☑ No has e 2 autopsy page performe this certificate director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 1 TYes 2[1]No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the f

29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835 HILLED 1 ASNEEm

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Medical

State

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2120-8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physici	an	Decedent's Name (First, Middle, Last)								2. Date of Dea Month	ath Day	Year	3. Time of	f Death
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)	Examin	er	4a. Facility Name (If not institution, give :						Location of	of Death			ounty of Death		
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	e u	ner	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Deced	ent of Hi	ispanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)	- 14	. Race - Ameri Black, White,		
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altimore,	Pages nent of nt: If it ry or o		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	cemete	ry, crer	natory or of	her place	(e)			200. 2000	o.	J. J. J. J. J. J. J. J. J. J. J. J. J. J	
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. Box	The law requires that the death certificate be executed its has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	4 Pregnant at	2 Fetal death		Ectopic pre					23	d. Date of deliv Month	,	Year
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É	or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, fac. (Specify)	arm, str	eet, factory	, office		2	8f. Location (S City or Tox		Number or Rur	al Route Num	nber,
	To the Hospitel or Atterwithin 24 hours after de To the Funeral Directe completely filled in by the	Medical C	29a. Certifier 1 Certifying Physical Cone 2 Medical Examination	sician: To the best ner: On the basis of and manner sta	f examination ar	e, deati	h occurred a vestigation,	at the tim	ne, date an pinion, dea	id place, a	and due to the	cause(s) a date and p	nd manner as : lace, and due !	stated o the cause(s	s)
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	To the within To the Comp	~	30. Name and address of person who of	impleted cause of d	leath (Item 23a)	(Туре,	Print)	D 2	Pan Pan	19	Star-	1 R	8/02	2/07	MD

09-06787 Vivian Bolling Medi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

ling		State of Maryland / D	Department of Certificate of		d Mental H	ygiene Reg. I	yo. 20	09 2379		
hysician/ Examiner	1	egistrar . Decedent's Name (First, Middle,Last) Vivian Bo	11ing			2. Date of Death Month Da August 31, 2	av Year	3. Time of Death 0655 hrs		
	4	Facility Name (if not institution, give street and number) 3030 Mallview Road		4b. City, Town, or Baltimore		i	4c. County of Dea			
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28a-f show any Latonce. ector	1		c. City, Town or Locat Baltimo			10g.	Citizen of What Co	10d. Inside City Limits 1 X Yes 2 No untry?		
nal", or items 23a or niner must be notified by Funeral Dir		3030 Mallview Road 1. Mantal Status 1. Never Married 2. X Married Armed Forces? 1 Yes 2. X 1 Yes 2. X 1 Yes 2. X 1 Yes 2. X 1 Yes 2. X 1 Yes 2. X 1 Yes 2. X 1 Yes 3. Yes 2. X 1 Yes 3.	No 1 1 16a. Deceder	212 as Decedent of His res, specify Cubar Yes 2 X No nt's Usual Occupar nost of working life	panic Origin? (S , Mexican, Puerto specify: ion (Give kind of	work done	White, etc.	arican Indian, Black, Lack S/Industry		
Hygiene. I other than "natu the Medical Exan Completed		College (1-4 or 5+) 2 years 7. Father's Name (First, Middle, Last)	Lic		18.Mother's Nam	e (First, Middle, Mai		a1		
27 is marked matic event,		Willie Her 9a. Informant's Name/Relationship (Type, Print) Mothe Deloris Robinson Jennings	19b. Mailin		et and Number or	Deloris Pe Rural Route Numbe Baltimore	r, City or Town, Sta			
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To the Funeral I completely filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stone) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (A								
4	;	80. Name and address of person who completed cause of dea Ana Rubio MD. Assistant Medical Examir	ner 111 Penn	Street, Baltim						
State Registra	-	31. Date filed (Month, Day, Year) 32 Registrar's SFP 1 0 2009		Med						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September **Physician** 2801 Frances C. Beck /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death GlenBurne ashination 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 204-30-9432 1 □ M 2 🗓 F Months Days Hours Min ^{Year)} 1938 Pennsylvania Director 70 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐Yes 2XNo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Benmere Rd. 21060 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 □Yes 2 No Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Camillo Campli Marie Detonno ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Benmere Rd., Glen Burnie, Maryland 21060 H. Carl Beck / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sept 2009 Chestnut Grove Cem. 4 □ Danation 5 □ Other (Specify) Marysville, Pennsylvania 21. Signature of Funer I Service 22, Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** TIP /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Tes 2 📑 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. M. nn of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 □Yes 2 □ No

executed Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician; The law requires that the death certificate be e 24 hours after death. Funeral Director; After this certificate has been signed by the attending physiciar

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r than "natural", or items 23a or 28a-f show the Mudical Exending must be notified at

death v

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Health and

permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra

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attending physician

the

signed by

is marked other

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Maryland

Baltimore,

Certification: To

Medical

State Registrar 29b. Signature and title of certifier

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 041365

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) September 1, 200

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Hen 23a) (Type, Print) Drive, Glen Burnie, 12

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

31. Date filed (Month, Day, Year)

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

₱ 32. Registrar's Signature

24 hours a

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #2per MD g895 9/10/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - State Amend 20b, per FH g895 9/10/09 Trifficate of Death Reg. No. 2. Date of Death Month **Sep** t pay 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 0 Ygar 0:50P Cooper Jacqueline Medical 4a. Facility Name (if not institution, give street and number) Baltimore 4b. City, Town, or Location of Death **Examiner** Towson Gilchrist Hospice Cebber 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD 1 □ M 2 🔽 F 68 Months Days Hours Min. 0 9 - 2 5 - 40 214-40-0802 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at within 72 hours after death with the Maryland rector YYes 2 No Baltimore MD NA 這 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21206 5619 Knell Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc African er than "natural", or the Medical Examin þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: American 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Social Security Administration life. DO NOT use retired) Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Computer Programmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk. မ Thomas Ernestine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Poll timore, MD 21206 19a. Informant's Name/Relationship (Type, Print) 5619 Knell Avenue Baltimore, Marvin A. Holley-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 09-10-09 Baltimore, MD Druid Ridge 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Funeral Home P.A. Wylie 22. Name and Address of Facility Gilmor Street Baltimore, MD 21217 638 N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Scheinic Trevy Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performa 2 🕶 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) No Spice ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

N-

Charles ST

Towson MM

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day 09 hristopher 2009 rrigan 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death raums 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1X M 2□ F Months Days Hours 215-31-8853 28 May13,1981 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Baltimore 1 ☐ Yes 2X No Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 929 Martin Road 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. Specify: Completed by White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SunRise Safety Co. Maintenance -MTO <u> 12th</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Carrigan Lisa Routzan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Carrigan Jr. /father 929 MArtin Road Baltimore MD 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 9/11/09 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. M D 21. Signature of Funeral Service Licensee Connelly Funeral Home of Essex 2122 23a. Part 1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Temothorax disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Ye ar 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ∐ Yes 2 **X**No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 □ No Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

other traumatic

Department of Heal Important: If item 2 any injury or other

Physician

/Medical

Examiner

Funeral

Director

3a or 28a-f show

Funeral Director

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Maryland 21215-0036

Baltimore,

or Attending Physician: The law requires that the death certificate be executed the burial-transit P.O. Box 68760, Records, After this certificate has been sign funeral director, page 2 should be **Division of Vital** this After

death.

dical Examiner Certificatio within 24 hours after deat To the Funeral Director: filled in by the

Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 r 1 □ Yes 2 □ 9 □ Unknown
by	Part II. Other signifi
Completed	
) Be	25. Was case referred examiner?
n: To	27. Manner of Death

Medical

1 Natural

3 Suicide

29a. Certifier

2 Accident

4 Homicide

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Baltimore, my

Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 No Driving 7 2009 01:30AM Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Essey Mary 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as staud.

(Check only 2 Medical Exa		the basis of d manner stat		n, in my opinion, death occurre	d at the time,	date and place, and due to the cause(s)
29b. Signature and title of certifier		11.0	296	c. License number (N6	T)	29d. Date signed (Month, Day, Year)
1	13	1/V190		111.71216	0	01012009

5 Pending investigation

Could not be

determined

NPI 29c. License number

SIL

29d. Date signed (Month, Day, Year) 2009

motorcycle

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rhodes Screene 22 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar amend 24a per Dr. g895 9/10/09 Gentificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 2009 Baby Boy Costello MAY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours 29 May 29, 5. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** ^{Year)} 2009 1 🛛 M 2 🗆 F Maryland Director infant Usual Residence of Decedent 10h County 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director Examiner must be notified MD Harford Joppa the 1 10e. Street and Number 10f Zin-Code 10g Citizen of What Country? 0 307 Blackburn Court items 23a 21085 USA Funeral death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or ite 1 X Never Married 2 Married 1 Yes 2X If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+)
infant infant infant infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephanie Costello Paul Demetro ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
600 Wolfe Street Baltimore, MD 21287 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 Is
any injury or other trau 600 Wolfe Street Baltimore, MD The Johns Hopkins Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 N Other (Specify) in state 21. Signature of Funeral Services icensee de Wade State Atatomy aboard 655 W. Baltimore Street Baltimore, MD 21201 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** CARDIDMYDPATH disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner SCITES Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of) Disseminated intravase attending physician and for use as the burial-trans that initiated events resulting in death) Last Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No No signed by the 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 Tes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 🗌 No 1 🗌 Yes certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ this 28a. Date of Injury (Month, Day Year) n 24 hours after death.

• Funeral Director: After th

pletely filled in by the funera 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation Injury 1 TYes 2 \square No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only Ž 🗔 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-OOP 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 BERNADETT CROWDER Date filed (Month, Day, Year) 32. Regi State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 6:15 MM Randolph Connolly, Jr. Richard September 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** len ISHYni Anne Baltimore Washington Medical Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday, **Funeral** Country) Maryland Months Days Hours Min. 1K M 2 □ F 220-18-5565 1928 Director FEB. 6, 81 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examination officed at 1 ☐ Yes 2 No Director Anne Arundel Co. Gambrills Maryland filed within 72 hours after death with the 10e. Street and Number 10g. Citizen of What Country? 21054 United States 2610 Chapel Lake Drive unit 109 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: White Specify: 3 Widowed 4 Divorced ? Is marked other than "natural", traumatic event, Inc. Product Exp. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Construction Supervisor 8 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental H, Important: If item 27 Is marked oth any filury or other traumatic event ance. Be Clara Hands Richard R. Connolly, Sr. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2610 Chapel Lake Dr. Unit 109 Gambrills, MD 21054 Mrs. Betty E. Connolly / Wife Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State tt Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park | 09/12/2009 | 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Ser 22. Name and Address of Facility Singleton Funeral & Cremation Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enocar on ome **Physician** 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Physician/Medical Examiner Due to for as a consequence off if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): 60 687 attending pl Box IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 □Yes 2 □No o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performe certificate Vital 1 ☐ Yes 21 1 □Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To o this After th 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation ours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) oxl and manner stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Mud

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #19a Per ANA BD State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 9009 YNSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number Calvert 9. Birthplace (State or Foreign Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Year) Days Min 1**⊞** M 2□ F 58 Yrs Maryland 267-92-5384 100 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic ever any injury or other ever any injury or other ever any injury or other ever any injury or other ever any injury or other ever any injury or other ever any injury or other ever any injury or other ever any injury or other ever any injury or other ever any injury or other ever any injury or other ever any injury or other ever any injury or other ever any injury or other ever any injury or other eve 10d. Inside City Limits 10a. State 10c. City, Town or Location t ☐ Yes 2X No St. Leonard Funeral Director Vert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6021 Fir Road 20685 USA 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married white 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) construction 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Hynson George Cole Sr. Juanita Durham ပ 19a. Informant's Name/Relationship *(Type. Print)* Lynda Linda Wagner/daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 39; Smithsburg, Maryland 21783 20c. Location - City or Town, State 20b Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☑ Donation 5 ☐ Other (Specify) of Funeral Service Licensee Ranald Sa Wade 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 23a. Part 1. Poter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (omonths colon Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2-11-No 1 ☐Yes 2 ☐No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 296. Signature and title of certifie 29c. License number f person who completed cause of ogath (Item 23a) (Type, Print) 30. Name and address 228 Date filed (Month, D Year) State 10

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year Rheta Clugston 2009 August 4:11 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕶 F 79 Oct 23, 1929 Director 167-40-3114 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified MD Anne Arundel 1 TYes 2 TVNo Director Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ö 21012 USA items 23a 817 Mill Creek Road Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: White þ 3 ₩ Widowed 4 Divorced 'natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry 117 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 7 is marked other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander Oliver Carter Agnes Macey မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 253 Old Mill Bottom Road; Annapolis, Maryland 21401 Timothy J. Brenza/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☑Donation 5 Other (Specify) 21. Signatur Funer Sure Licens State Anatomy Board; 655 W. Baltimore Street Wade Baltimore, Maryland 21201 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause in each line. Immediate Caus. (Final disease or conditions of the cause of th Approximate Interval Between Onset and Death Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Y CARY ORONARY THEROS CLEROSIS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician ar Due to (or as a consequence of) Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2☐NO 3☐ Probably 4☐Unknown DIABETES 1 ☐ Yes been PERTENTION 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate har irector, page 2 DYSLIPIOEMIA 2 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA uneral dir this 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760 Division or Vital Records, Hospital the

or Attending Physician: s after death.

I Director: Al within 24 hours at To the Funeral C filled

> State Registrar

DHMH 17 Rev 1/2001

Medical

30 1

29a. Certifier

(Check only one)

29b. Signature and title

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of certifier

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

037064

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Evelyn Marie Cornell 10:00 A.M September 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie 1018 Sunnybrook Drive If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Year) Days Hours Months 1 □ M 2 🛛 F Maryland 83 08/07/1926 212 22 0614 **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10a. State d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be multified at 1 □Yes 2 No Director Anne Arundel Glen Burnie Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 U.S.A. 1018 Sunnybrook Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ∐Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the May pigury or other traumatic event, the May ones. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Daniel Kisser Elsie Marie LaBarre ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Cornell / Son 1018 Sunnybrook Drive Glen Burnie, Maryland 21061 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/10/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, prock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ANTELIOSCIENTIC CARDIOVASEULAN **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off Hospital or Attending Physiclan: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, $_{arphi}^{\smile}$ Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month in the past 12 months? Day 5 ☐ Other (specify) □Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 No 1 ☐Yes 2 ☐No 24 hours after death.

Funeral Director. After this certific etely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number SEPTEMBER 8, 2009. Ms Attending D 21776 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RITCHIE HWY, PASADENA, MY 21122 8021 MUNDEA MINDRA MO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 0 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death CHARNEY MARY FLLEN 2:05 Α September 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Hospice of the Chesapeake Tate House Linthicum Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days Hours 212-20-2373 Nov 6, 1924 84 Maryland 1 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Glen Burnie Maryland Anne Arundel 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21060 6526 Clear Drop Court, #102 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Conrail Office Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Mildred K. Chronister Edgar Allen Wolfrom 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Charney Smith (Daughter) 115 Fordham Drive, Millersville, Maryland 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/11/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Ometery 21. Signature of Funeral Service Licensee Kevin E Fcker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 East Patapsco Ave., Baltimore, Md. 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2K No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2♥ No 24a. Was an autopsy perform 2 1No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 11050rcf Hospital: 1 ☐ Yes

Physician /Medical Examiner

the death certificate be executed

P.O. Box 68760

Division of Vital Records,

To the Hospital or Attending Physician:

death.

within 24 hours a

filled in by the

Physician

/Medical

Examiner

Funeral

Director

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ir than "natural", or items 23a or 28a-f show the Madicial Examinar must be notified at

Director

Funeral

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Baltimore, Maryland 21215-0036

and burial-tra attending physician for use as the buria signed by the a been si has certificate

Examiner Physician/Medical 2 Completed Be ٩ funeral after death

Certification:

Medical

State Registrar

Other: 4 Nursing Home 5 Residence 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\text{Homicide} \) 29a. Certifier Cartifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V

31. Date filed (Month, Day,

32. Registrar's Signatur

		•	= State Registrar			Ce	rtificate of	Death			Reg. No. 2	0.09	20809
	Physicia		1. Decedent's Name (First, Middle Hilda	e, Last)	Cor	10 h				2. Date of De Month	nber 06	Year 2009	3. Time of Death 0906 A M
	/Medic Examin	er	4a. Facility Name (If not institution SEASONS HOSPICE		mber)		4b. City, Town, o	r Location	of Death		4c. Count	y of Death	
	Funeral Director		5. Social Security Number 212–16–6704	6. Sex		FIIAL s. last birthday Yrs.			24 Hrs. Min.	8. Date of Bi		O District	lace (State or Foreign POLAND
3	0		Usual Residence of Decedent								,		0d. Inside City Limits
	rarylar f show	ō	10a. State 10b. County	TIMORE	10c. C	City, Town or L	GS MILLS						1 ☐ Yes 2 🛣 No
4	r 28a-	irect	10e. Street and Number	TIMORE		OWIN	10f. Zip Code				10g. Citizen of	What Cour	ntry?
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000	Is 1 and 2 should be lined within 72 hours arer beam with the maryland if Health and Member Hygiene. If the Tris marked other than "natural", or items 23a or 28a-f show other traumatic event, the Healtest Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Mar 3 M Widowed 4 Divorced	ried Armed Fo	_2 X No ve	J.S. 13.	Was Decedent of H If Yes, specify Cub 1 □Yes 2 1 No	lispanic O an, Mexica Specify		ecify Yes or No Rican, etc.)	o- 14. Ra Bla Speci	ce - Americ ick, White, fy: WHI	etc.
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= 3	set all H) Be	17. Father's Name (First, Middle, LEIB	Last)	WOLL	ACH		18. Motr	ers Name MAT		e, Maiden Surna	me) RENI	JI E
מו א	and Mer ls marke aumatic	L	19a. Informant's Name/Relations	ship (Type. Print)			ing Address (Street	and Numl			ber, City or Towr		
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5	iges into the control of corotty		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		State	cemetery, cre	osition (Name of ematory or other pla			Date	20c. Location	•	
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be death cortii	The tropped at treeming ripsidary, the taw requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2□Fe ∣nant at time of	tal death 3	☐ Ectopic pregnan	су				ate of deliv	ery Day Year
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130	death ctor / y the f	Certification:	3 Suicide 6 Could	not be 28e. Place	e of Injury - At	home, farm, si		Yes 2		28f. Location	Street and Num	ber or Run	al Route Number,
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-	171		30. Name and address of person Roggen	who completed causes	se of death (Ite	em 23a) (Type	ad Suite	108	5 1	Randal	latown	mo	21133
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician Inez R. DeWitt /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Lutheran Village Westminster If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 0 0 0 1 2 8 2 1 9 2 3 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 M 2 F 155-18-9081 85 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County a or 28a-f sh Director Carroll Westminster MD 10f. Zip Code 10e. Street and Number 21158 205 St. Mark Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify þ 3 AWidowed 4 □ Divorced Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teller 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Seebren Trina Reyenga ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Frederick, 19a. Informant's Name/Relationship (Type. Print) 8914 Mountainberry Circle David DeWitt-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □Removal from State 9-7-2009 Westminsster, MD 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home D. Komas 254 E. Main St. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Physician /Medical Examiner

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attending physician

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e Hospital or Attending Pl 24 hours after death. Pruneral Director: After the

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requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

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Physician/Medical

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Certification:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

le c	cause on each line.	Onset and
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D	Intra Cenebal Hemmeryea	2-2
D	Adrama Alzham Dennton Due to (or as a consequence of):	
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IF FEMALE 23b. Was decedent pregnant

in the past 12 months? 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death 9□Unknown

3 □Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Vear

21157

3. Time of Death

10:00P M

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

New Jersev

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business/Industry

21702 20c. Location - City or Town, State

MD

14. Race - American Indian,

Banking

white

Black, White, etc.

USA

Westra

Westminster,

Date

Carroll

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 No 3 Probably 4 Unknown 24a. Was an

autopsy perform 1□ Yes 20 No 26. Place of Death (Check only one)

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural

2 Accident

3 ☐ Suicide 4 Homicide

1 Inpatient 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge death perfered at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. 29a. Certifier 2 ☐ Medical Examiner:

29b. Signature and title of certifier

stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed

State Registrar ause of death/(Item 23a) (Type, Print)

bereu 32. 31. Date filed (Month, Day,

6 Could not be determined

Registrar's Signatur

DHMH 17 Rev 1/2001

e of Maryland / Department of Health and Mental Hygiene	2009	298
Certificate of Death Reg. No.		

Physician
/Medical
Examiner

Funeral

Director be filed within 72 hours after death with the Maryland 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Exaction roust be rediffed at al Hygiene. h and Mental F 7 is marked ot other traumatic

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

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Important: If iter
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or Attending Physician: The law requires that the death certificate be executed and burial-tra attending physician the nse per signed by the has page 2 certificate this funeral After 24 hours after death. Funeral Director: A completely filled in by the Hospital

Division of Vital Records, P.O. Box 68760,

For State Registrar 3. Time of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 20:35 PM 28, 2009 Samantha Jeanne Dupont August 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital Rockville Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Min 1 □ M 2 X F Months Days Hours 214-34-6703 71 09/30/1937 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 No Funeral Director Gaithersburg Maryland Montgomery 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 20878 USA 896 Flagler Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify Specify: White Completed by 3 Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Association 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claude Williams Helen Louise Yarborough ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19515 Newberry Terrace, #304, Leesburg, VA 20176 Georgia Duckworth, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Funeral Choices of Chantilly 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 09/04/2009 4 □ Donayon Chantilly, Virginia 5 ☐ Other (Specify) 21. Sign 22. Name and Address of Facility Funeral Choices of Chantilly #CC0508 Gary Roles Downer 14522L Lee Rd., Chantilly, Virginia 20151 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Vaginal Cancer disease or condition resulting in death) Due to (or as a consequence of) Small Bowel Obstruction Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Anemia resulting in death) Last Due to (or as a consequence of): Physician/Medical Sepsis IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ⊒Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Respiratory Failure, Hematuria 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 X No 1 □Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 XXNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 1/2001

within 2

Janelle Williams 31. Date filed (Month, Day, Year)

32. Redistrar's Signature

9901 Medical Center Drive, Rockville, Maryland 20850

09-0	6839
Roy	Davis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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l-m	-	J	-		0	0		1

,	Davis		- For State Registrar	Certi	ificate of Dea			∠ U U eg. No.	9 2881
Me	Physici dical Exami	an/ ner	1. Decedent's Name (First, Middle,Last)			-	2. Date of Deat Month	Day Year	3. Time of Death 1222 hrs
)	101	Roy James Davis, Sr. 4a. Facility Name (if not institution, give st	eet and number)	4b. City,	Town, or Location of	Septembe of Death	4c. County of Death	
1	1		St. Agnes Hospital		Balti	more			
	Funeral Director			7. Age (In yrs. las	t birthday) If Und Mont Yrs.			th(MM/DD/YYYY) 9. Bir Foreig Co	
	any	ı	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Location			-	10d. Inside City Limits
	≱ ['n	MD	Balt	imore				1 Yes 2 No
9	Maryla r 28a-f ed at o	Director	10e. Street and Number			p Code	10	og. Citizen of What Cou	ntry?
7	ith the 123a o		2713 Baker Street 11. Marital Status	. Was Decedent Ever in U.S.	13 Was Deced	21216	gin? (Specify Yes or No-	USA 14 Race - Amer	ican Indian, Black,
100	imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married 2 X Married	Armed Forces? X Yes 2 No			, Puerto Rican, etc.)	White, etc.	ican indian, Break,
Dr.	after cral", o	by F	3 Widowed 4 Divorced If Y	es, Give 1965-1967 Dates: 1965-1967		No specify:			an-American
	2 hours "natu		15. Decedent's Education (Specify only hard Elementary/Secondary (0-12)	ighest grade completed) College (1-4 or 5+)	6a. Decedent's Usua during most of wo	I Occupation (Give orking life. DO NOT		16b. Kind of Business/	Industry
	036 ithin 7. ne. r than Iedical	Completed	12th	,	1	labor		Zimmerman_Co	mnemv
	filed w Hygie d othe	င္ပ	17. Father's Name (First, Middle, Last)			18. Mother	's Name (First, Middle, M		1.0.9
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours al Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	To B	Roy O. Davis 19a. Informant's Name/Relationship (Type	Print)	19b. Mailing Addres		rta Mosten nber or Rural Route Num	ber, City or Town, State	e, Zip Code)
	MD nd 2 sho alth and m 27 is aumati		Carolyn A. Davis / Wif				ltimore. Maryl	and 21216	
	of Heal	П	20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State cre	ace of Disposition (Na ematory or other place	e)	Date	20c. Location - City or	Town, State
	Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature Huneran Service Los see	Gan	rison Forres		9/10/2009	Owings Mill	s, Maryland
			1UNIC Cele		9200 Lil	berty Road 1	Wylie Funeral Randallstown,	. Homes P.A. o Maryland 2113	f Balto. Co.
1	Physician /Medical		23a. Part I. Enter the disease, or complice failure. List only one cause on each	qe.	o not enter the mode	or dying, such as c	ardiac or respiratory arre	est, snock, or neart	Approximate Interval Between Onset and Death
1	xaminer			to (or as a consequence of):					
		_	Sequentially list conditions, b	to (or as a consequence of):					
		Examiner	cause. Enter Underlying Cause						
	uted d ansit	Exa	events resulting in death) Last Due d.	to (or as a consequence of):					
	760, ficate be executed g physician and the burial - transit	Medical	X UNPENDED A	MENDED 23a,PII,	27,perME,	g896 10/2	28/09 TT		
	3760, ficate be g physic s the bur	Me	IF FEMALE: 3b. Was decedent pregnant in the	3c. If yes, outcome of pregna		3 Ectopic	c pregnancy	23d. Date of deliver	y Day Year
	Sox 687 leath certific e attending p for use as th	sician	past 12 months?	Pregnant at time of deat			o pregnancy	Mouth	Day Teal
	the dea y the a	Phys	1 Yes 2 No 9 Unknown Part II. Other significant conditions co	Unknown	ulting in the underlyin	n cause given in Pa	art I 23e Did to	bacco use contribute to	the cause of death?
	ires that the de signed by the	<u>ام</u>	Chronic obstruct	-		•			bably 4 🗸 Unknown
	rds,	Completed	fibrosis	_ _	-		24a. Was a		utopsy findings available completion of cause of
	n of Vital Records, ling Physician: The law requir After this certificate has been sfuncial director, page 2 should	ошо						med? death?	
	tal R	Bec	25. Was case referred to medical examiner?	ital: 1 ✓ Inpatient 2 E		26.Place of Death			
	of VI Physic ter this eral dir	P	1 Yes 2 No 27. Manner of Death		R/Outpatient 3 28b. Time of Injury	DOA Other; 28c. Injury at Work		Residence 6 Othe	r:
	OD C ending sath. or: Af the fun	틽	1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)		1 Yes 2	,		
	ivisior or Attend after death Director: d in by the	Certification	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	ne, farm, street, factor	y, office building, et	c. 28f. Location (S or Town, S		ural Route Number, City
	Di ospital hours a		4 Homicide determined	(Specify)					
1)	Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	one) 2 ✓ Medical Examiner:Or	To the best of my knowledge the basis of examination and					
	F ST	Me	29b. Signature and title of certifier	manner stated.	29	c. License number		29d. Date signed (Mo	nth, Day, Year)
-			MU	> 1		O.C.M.E.		September 2, 20	009
ļ	8 1	Ì	Name and address of person who com Russell Alexander MD. As	pleted cause of death (Item 2 sistant Medical Exami		Street, Baltimo	ore, MD 21201		
	S	ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature					
	Regis		SEP 1 0 2009	Denous D.	Marko				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend Item 29d per dvr., g895, 09/15/09dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2009 PUNGAN 936 M JE)E99E /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE SHOCK TRAUMA If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
MD 5. Social Security Number 8. Date of Birth (Month, Day, Year)
Sept. 12, 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 219-32-3620 71 1937 Director Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Anne Arundel Pasadena 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 1700A Bayside Beach Rd. 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: δ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Customer Relations Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Jesse Milton Dungan, Sr. ပ Clara Ruth Gurry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn L. Dungan, wife 1700A Bayside Beach Rd. Pasadena, MD. 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 09-10-09 Glen Burnie, MD 22. Name and Address of Facility
Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd. 21. Signature of Funeral Service Licensee Cople Arbutus. 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SERVINGE TO BE REAL TO STATE OF THE PARTY OF Immediate Cause (Final **Physician** a. CONSESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner N 2 WKS CARDIOGIENIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): NIMU be executed burial-transit FAILURS RESPIRATORY and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician NIMO. Physician/Medical INTRA-ABDOMINAL the attending phase as the IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 5 Other (specify) the been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HAKYLOSING SPONDYLITIS Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 🛚 No n 24 hours after death.

■ Funeral Director: A

pletely filled in by the fu death. 2 Accident 3 Suicide 07-31-09 YUNDOWO W FALL IN SHOWER 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide (MD) HOMF 1700A BAYSIDE BEACH RD PASADENA To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

8+1

State Registrar AN 194

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

A. GIBSON M.D.

Registrar's Signature

9. GREENE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIRGON MO

GILLOU

BANTIMURE

MD

Please Type or Printin Black Indelible Ink 1 From Rd Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** 2:00 AM 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of D Baltimore City, Town, or Location of Death **Examiner** None Medical Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7, Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 € M 2 ☐ F 220-30-6347 72 Aug. 7, 1937 Director Georgia Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show 1 Tyes 2 □ No id other than "natural", or items 23a or 28a-f slevent, the Medical Examiner must be notified Director N/A Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with item of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, Item Social Examine mast be any USA 21201 300 N. Fremont Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 8 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ∐Yes 2 🛛 No Specify Specify: ģ 3X Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Sparrows Point Steel Elementary/Secondary (0-12) College (1-4or 5+) <u>12th grade</u> Brick Layer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unk. Geneva ပ <u>Larry Frank Davis</u> 19a. Informant's Name/Relationship (Type. Print) Life 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 N. Fremont Avenue Baltimore, Maryland Lorraine Ledbetter/ permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tr once. Companidn 20b. Place of Disposition (Name of cemetery, crematory or other place)
Woodlawn Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 9/10/09 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityChatman-Harris FuneralHome 21. Signature of Foneral Service Licensee. 5240 Reisterstown Rd Baltimore,MD 21215 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 48 Hours **Physician** /Medical Due to (or as a consequence of) **Examiner** non-small cell lung concer Equalitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760 Physician/Medical the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a □ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has birector, page 2 s autopsy 1 ∐Yes 2 12 No 1 ☐ Yes 2 No this certific al director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) NPI 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 St Paul Place Baltimore MD 21202 Medical 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

F	Physi	ician
	/Me	dical
	Exan	niner

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at anone. Since:

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

မ

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1 - State Registrar				Ce	rtificate	of Death		F	Reg. No.	2009	28819
1. Decedent's Name	e (First, Middi	e, Last)					2	. Date of Dea			3. Time of Death
Wilson		Owen		Delar	wder		S	Month eptemb	er 2	, 2009	12:00P ^M
4a. Facility Name (/	If not institutio	n, give street and nu	mber)		4b. City, Tov	vn, or Location	of Death	-	4c. C	ounty of Death	
7767 Ov	erhill	Road			Glen	Burnie			Anı	ne Arun	de1
5. Social Security N	lumber	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 \		24 Hrs. 8	B. Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign
213-24-6	402	1 🔀 M 2 🗆 F		76 Yrs.	Months	ays Hours		ec. 14			MD
Usual Residence of			1								404 1-14-01-14-14-
10a. State	10b. County			ty, Town or Lo							10d. Inside City Limits
MD	Anne	Arunde1	GL	en Buri							1 ☐ Yes 2 ∏ No
10e. Street and Nur					10f. Zip Co	ode			10g. Citize	en of What Cou	intry?
7767 Ov	erhill	Road			2106				U.S.A	Α.	
11. Marital Status		12. Was Dec Armed Fo	edent Ever in U	.S. 13.	Was Deceden	t of Hispanic Or Cuban, Mexica	rigin? (Spec n, Puerto R	ify Yes or No- ican, etc.)	14	 Race - Amer Black, White. 	
1 Never Marri		ried 1 [7]Yes If Yes. Gi	2 🗌 No		1 □Yes 2			,			ite
3 Widowed	4 Divorced	Year or D									
(Spec	 Deceder cify only higher 	nt's Education est grade completed)		(Give	dent's Usual C kind of work of	tone during mos	st of working	, 1	16b, Kind	d of Business/Ir	ndustry
Elementary/Seco	ondary (0-12)	College (1-4or 5+)		DO NOT use i	retired)					
12	/=: A 44: 4.14	1 0		Sale	es	40.34-11		First, Middle,	Foc		
17. Father's Name Lester		,							Maldell S	urname)	
				1			ra Wh				
19a. Informant's N						treet and Numb					
		. Delawder				hill Ro					
20a. Method of Dis		3 Removal from	State 20b. I	Place of Dispo cemetery, cre	osition (Name matory or othe	of r place)	Da Septem		20c. Loc	ation - City or T	own, State
4 Donation				en Have	en Mem.	Park			G1en	Burnie	, MD
21. Signature of Fu	uneral Service	Licensee	,			Address of Facil			Funer	al& Cr	emation
DU	eme.	wilks	MO14		ervices						e, MD 21061
23a. Part 1. Enter t	the disease, o	r complications that	caused the deat	h. Do not en	ter the mode of						Approximate Interval Between
Immediate Cause	(Final	only one cause on t	each line.		_	1				19	Onset and Death
disease or condition resulting in death)	on	a. Due to	(or as a consec	surface of):	4	me	_				
		Due to	Of as a consec	A CONTRACTOR							
Sequentially list co	nditions, nmediate	b	(or as a consec	uence of):							
Sequentially list co if any, leading to im cause. Enter Unde Cause (Disease or	allying → injury	S	100.	1 /21	1	Com		Jan		. "	
that initiated events resulting in death)	S	cDue to	(or as a consec	uence of):	nope		`				
			has 1	4 6		-					
		d	Just	ins							
IF FEMALE:		23c. If yes, ou	tcome of pregn	ancv					2	2d Data of doli	VOD.
23b. Was deceden in the past 12	months?	1 Live	birth 2 Feta	al death 3	☐ Ectopic pred ☐ Other (spec			23d. Date of delivery Month Day			
1 ☐ Yes 2 [9 ☐ Unknown		9 ☐ Unki		death 5t	_ Other (spec	···y/					
		ons contributing to d	eath but not res	sulting in the u	ınderiving caus	se given in Part	l.	23e. Did to	bacco us	e contribute to	the cause of death?
3		g			,,	9		15 X Y	′es 2 🗆	INo 3□ Pro	obably 4 🗖 Unknown
								24a. Was a autop	sy	prior to c	topsy findings available ompletion of cause of
								perfor	rmed? 2 No	death? 1 ∐ Yes	2 □No
25. Was case refer examiner?	rred to medica					26. Plac	e of Death	(Check only o	ne)		
1 ☐ Yes	No	Hospital:	Inpatient 2] ER/Outpatie	nt 3 🗆 DOA	Other: 4 🗆 N	lursing Hom	e 5 Resid	lence 6	☐Other (Spec	cify)
27. Manner of Deat		28a. Date	of Injury hth, Day, Year)	28b. Time o	of 28c	. Injury at Work?	28	3d. Describe h	ow injury	occurred	
1 Natural 2 □ Accident		igation	, , ,		М	1 ☐ Yes 2 ☐]No				
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could detern	oined 28e. Place	e of Injury - At h	ome, farm, st	reet, factory, o	ffice	28	Bf. Location (S City or Tow	Street and	Number or Ru	ral Route Number,
		Julia		.,,				0.1, 0. 1011	,		
29a. Certifier		ng Physician: To th									
(Check only one)	∠ ∟ Medica	Examiner: On the land man	nner stated.	alion and/or ii	rivestigation, in	i iriy opinion, de	ain occurre	u at the time,	gate and	piace, and due	to the cause(s)

State Registrar

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

mo

2106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Marylar	nd / Department of Health and M	ental Hygiene
			1 - State Registrar	Certificate of Death	Reg. No. 2009 28816
г	Physici	an	1. Decedent's Name (First, Middle, Last)	,	2. Date of Death Month Day Year 3. Time of Death
	/Medic	cal	Morunfolu Mercy Daniels	5	08 30 2009 2:15 PM
200	Examin	ier	4a, Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death Prince George's
	Funeral		5. Social Security Number (6. Sex 7. Age (In yrs.		8. Date of Birth 9. Birthplace (State or Foreign
С	Director		None 10 M 2005	Yrs. Months Days Hours Min.	(Month, Day, Year) O8 30 2009 Maryland
	Б.		Usual Residence of Decedent	· · · · · · · · · · · · · · · · · · ·	
	anyla shov	'n	111	ty, Town or Location	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	the N 28a-f	Director	10e. Street and Number	anham 10f. Zip Code	10g. Citizen of What Country?
	with sa or t be r				United States
	ms 2;	Funeral	11 Marital Status 12. Was Decedent Ever in U		cify Yes or No- 14. Race - American Indian,
စ္	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Examiner must be notified at	Ē	Armed Forces? 1 Dever Married 2 Married 1 Yes 2 10 No If Yes. Give	1 Yes, specify Cuban, Mexican, Puerto	
21215-0036	nours ural"; I Exa	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify: Black
15	"nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of workil life. DO NOT use retired)	ng 16b. Kind of Business/Industry
12	withi iene. than the M	шo	Elementary/Secondary (0-12) College (1-4or 5+)	None	NONE
	be filed within ital Hygiene. d other than "event, the Mer	Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)
Maryland	uld be Menta Irked Itic ev	To E	Olabinton Daniels	Olubuk	iola Daniels
lan	2 should and Mer is marke raumatic		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number or Rura	Route Number, City or Town, State, Zip Code)
	1 and Health Pm 27 ther tr		Olubukola Daniels / Mother		rden Parkway
Jore	Pages 1 nent of 1- int; If Ite iry or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Place of Disposition (Name of Cemetery, crematory or other place)	ate 20c. Location - City-or Town, State
Baltimore,			4 Donation 5 Other (Specify) in State	22 Name and Address of Facility	(55 N. P. 1.1.
Ba	permit. Departr Importa any Inju	i	21. Signature Funeral Service Licensee Minade Mirecto:	Baltimore, MD 2120	655 W. Baltimore Street
	-		23a. Part 1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line.		
	Physician		Immediate use (Final disease or condition	DE PAFMATUR	Onset and Death Onset and Death
7	/Medical		resulting in death) a. Due to (or as a consequence)	juence of):	" (MOUNTY A) BILLE
	Examiner	Examiner	Sequentially list conditions.		
3-1-12	led sit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	uence of):	
	cate be executed physician and the burial-transit	xan	that initiated events resulting in death) Last	quence of):	
8760,	e be e	dical E			
ထ	tificat ng phy as th	fedi			
Вох	eath certific attending p for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the post 10 profits? 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fets		23d. Date of delivery
	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 4 □ Pregnant at time of c 9 □ Unknown 9 □ Unknown		Month Day Year
P.0	hat th	Phy	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?
Records,	w requires that the di been signed by the should be detached	d by	, a	dailing in the disconying educe given in Fact.	1 ☐ Yes 2 ☐ 16 3 ☐ Probably 4 ☐ Unknown
CO	w req	lete			24a. Was an 24b. Were autopsy findings available
	The lav	Completed			autopsy prior to completion of cause of death?
Vita		Be C	25. Was case referred to medical	26. Place of Death	1 Yes 2 No
	nysici nis ce direc	To B	examiner? 1 Yes 2 No Hospital: 1 patient 2	Other:	me 5 ☐ Residence 6 ☐ Other (Specify)
0	ding Ph h. After th funeral		27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time of lnjury 28c. Injury at Work?	28d. Describe how injury occurred
Sio	tendl leath. tor: A the fu	cati	2 Accident investigation	M 1 ☐ Yes 2 ☐ Did	
Division or	after of Direction by	Certification:	4 Homicide determined 286. Place of Injury - At In-	ome, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	spita nours neral		29a. Certifier 1 Certifying Physician: To the best of my kno	owledge, death occurred at the time, date and place, a	and due to the cause(s) and manner as stated.
	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certification the funeral director, to the funeral director, the funeral director.	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	ation and/or investigation, in my opinion, death occurn	ed at the time, date and place, and due to the cause(s)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			D: Markon	MD crience 200	57034 27/02/09
			30. Name and address of person who completed cause of death (Iten	m Diriting 200 n 23a) (Type, Print) Laurel Region	7360 Van Dusen Ro
	Sta	te	31. Date flied (Month, Day, Year) SEP 10 2009 32. Registrar's Signa	ature Luurel Region	nal Hospital Laurel, MD 20707
	Registr		SEP 10 2009 Seneur	B. parket	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September Baby Boy Dickens 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner 8. Date of Birth (Month, Day, Year) Sept 1, 2009 9. Birthplace (State or Foreign If Under 1 Year Months 1 ☑ M 2 ☐ F Maryland infant Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1√2Yes 2□No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5102 Goodnow Road #H 21206 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 21∑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No black Specify ۾ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Dunbar Raven Dickens ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Franklin Square Hospital 9000 Franklin Square Drive Rosedale, MD 21237 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4□Donation 5 MOther (Specify) in state 21. Sign to e 1 Francis Project Licensee State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Patt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) enita Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Lectopic pregnancy Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 X No 1 🔲 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Dupatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 1 ☐ Yes 2 ☐ No

Examiner The law requires that the death certificate be executed and burial-trar Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria peen has Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Hospital or

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, If a Medical Exaction must be notified at

Physician /Medical

Baltimore, Maryland 21215-0036

Physician/Medical þ Completed Be မ Certification:

5 ☐ Pending investigation 2 🛮 Accident 6 □Could not be

3 Suicide determined 4 Homicide

29b. Signature and title of certified

29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

in Square Drive

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

State Registrar

Medical

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ DiMaggio Suzanne Barbara 2009 аум September 1:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 Tx Months Country) Director 220-52-4206 61 11/12/1947 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore MD Towson 1X Yes 2 ☐ No 10f. Zip Code 21204 10e, Street and Numbe 10g. Citizen of What Country? 23a Kenilworth Park Drive, Apt. 4C Funeral 101 items death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes : 2 X No Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than, Elementary/Seconday (0-12) College (1-4 or 5+) and 2 should be filed within Health and Mental Hygiene. tem 27 is marked other tha Real Estate 12 Office Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Maerz Mary Elizabeth Morrow 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
11 N. Woodstock St., Arlington, VA 22207 Jerry Maerz / Brother permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ardent Crematory or other pl 9/8/2009 Hanover, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Dorota Marshall Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Complications of advanced ovovian Early disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequerior of) if any leading to immedicause. Enter Underlying Exami that the death certificate be executed Cause (Disease or linjury that initiated events and-trar resulting in death) Last Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) the 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown or Attending Physician: The law requires Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 this certificate 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 XNo Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\) Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Funeral Director; After the sted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the Sest of my knowledge, Seath occur id at the time, date and place, and due to the cause(s) and marker as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R149194 CRNP 8,2009 Colmbr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print' Charles navian Grant IV. Towson. 31. Date filed (Month, Day, Year) State SEP 10 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and Nortificate of Death		0000	28810
	Physicia		1. Decedent's Name (First, Middle, Last) George W. Elzey, Sr.		2. Date of Death Sept. 0	^{Pey} , 20 [°] 0°9	3. Time of Death 8:15A м
1	/Medica		4a. Facility Name (If not Institution, give street and number) 811 Lindy Lane	4b. City, Town, or Location of Death Huntingtown		4c. County of Death Calve	rt
	Funeral Director		5. Social Security Number 6. Sex 2.18 - 0.5 - 8.6.2.5 2.1 4. Age (In yrs. last birthday, 9.1 Yrs. Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Day, Ye	ar) 9. Birthp Cour	place (State or Foreign
puelvie	show		10a. State 10b. County 10c. City, Town or Li MD Calvert Hunting			1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the A	3a or 28a-f show	I Direct	10e. Street and Number 811 Lindy Lane	10f. Zip Code 20639	10g.	Citizen of What Cour	ntry?
d 21215-0036 fled within 22 hours after death with the Maryland	al", or items 2	Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Spfif Yes, specify Cuban, Mexican, Puerto □ Yes 2 No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Ame	^{et} African
Baltimore, Maryland 21215-0036	ene. than "natural", s. Medical Ex	mpletec	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) CTVISOT	ing	o. Kind of Business/In	_{dustry} L Service
land 2	eve eve	To Be Co	17. Father's Name (First, Middle, Last) Charles W. Elzey, Jr.		e (First, Middle, Maid ana Das	den Surname) shield	
, Mary	salth and Mer 27 is marke er traumatic	3	* * * * * * * * * * * * * * * * * * * *	ng Address <i>(Street and Number or Run</i> Lindy Lane Hun			
imore	artment of Health a ortant: If item 27 is Injury or other trauge.		4 Donation 5 Other (Specify)	armony Mem. Pk.	9-14-09	Landove	er, MD
Balt	Department Important: any Injury conce.		Junela gones 6.	2. Name and Address of Facility Wy 38 N. Gilmor St	reet Bal	timore,	MD 21217
	nysician Medical xaminer		23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Charles No. 100	or respiratory arrest,		Approximate Interval Between Onset and Death
	iysiclan and ne burial-transit	ical Ex	Sequentially list conditions, that y leading the last cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Last (or as a rouse union): c. Due to (or as a consequence of): d.				
ords, P.O. Box 68760, requires that the death certificate be executed	by the attending phy ached for use as the	Completed by Physician/Med		□ Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
ouires that	been signed by the should be detached	ed by P	Part II. Other significant conditions contributing to death but not resulting in the Coronary Art		23e. Did tobac 1 ☐ Yes	co use contribute to t	he cause of death? bably 4 🗌 Unknown
I Rec	ate has b	Complet			24a. Was an autopsy performed	prior to co d? death?	opsy findings available impletion of cause of 2 No
of Vita	is certific director,	Be	25. Was case referred to medical examiner?	Other	th (Check only one)		
of Phys	this all dir	၉ .	1 Inpatient 2 EH/Outpatie			e 6 ☐ Other (Speci	fy)
Division of	death. :tor: After / the funer	Certification: To	27. Manner of Death DNatural 5 □ Pending investigation 3 □ Suicide 6 □ Could not be	Work? M 1 □ Yes 2 □ No	28d. Describe how i	njury occurred	al Pouta Number
Div			28e. Place of Injury - At home, farm, st building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea		City or Town, S	State)	
the Hos	hin 24 h the Fur npletely	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or i and manner stated.	nvestigation, in my opinion, death occu	rred at the time, date	and place, and due t	o the cause(s)
٥	V Vitl	2	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	
	2 1		30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Jonathan Lowenthal, MD 13	Print) O Hospital Roa		ince Fre	ederick, MD 20678
	Stat		31. Date filed (Month, Day, Year) 32. Registrar's Signaturië	W		,, 0 = 0	

DHMH 17 Rev 1/2001

Dec: George W. Elzey, Sr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-07034 State of Maryland / Department of Health and Mental Hygiene Connie R. Evans 1- For State Certificate of Death Reg. No Registrar 3. Time of Death Decedent's Name (First, Middle,Last) 2 Date of Death Physician/ Month Day September 9, 2009 0120 hrs Medical Examine Connie R. Evans c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore County Franklin Square Hospital If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY) | 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Months Days Hours Director 213-66-5319 Sept.10,1955 Country MD 1 M 2X F 53 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State Yes 2 X No MD Baltimore Middle River or 28a-f show must be notified at once, Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1320 ChesapeakeAvenue 21220 USA items 23a 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces 1 Never Married 2 X Married 2 X No Yes White 1 Yes 2 X No specify: If Yes, Give Year Widower Divorce ğ 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Federal Elementary/Secondary (0-12) College (1-4 or 5+) 72.1 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " injury or other traumatic event, the Medical secretary Government 21215-0036 1yr 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Nesbit Hugh Reynolds Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1320 Chesapeake Avenue Baltimore MD 21220 Robert Evans /husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date Bayview Crematory Burial 2 X Cremation 9/10/09 Baltimore MD Donation 5 Other Specify 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Si nature of Funeral Service License Connelly Funeral Home of Essex 21221 23a. Part I. Enter the disease, or complications that daysed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Medical Death Oxycodone intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last AMENDED 23a, PII , 27, 28a-f, permE, g895 9/22/09 TT Physician/Medical X UNPENDED attending physician or use as the burial certificate be Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) requires that the death Yes 2 No 9 V Unknown g Unknown s been signed by the נ should be detached בי 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö ð Yes 2 No 3 Probably 4 ✔ Unknown Hypertensive atherosclerotic cardiovascular disease نم Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available Chronic obstructive pulmonary disease prior to completion of cause of autopsy aw has death? performed' Yes 2 ✔ No gastrointestinal hemorrhage Colon cancer; 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: 24 hours after death. Be Other₄ examiner? Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient DOA this 1 Yes ဥ No 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 28b. Time of Injury After 27. Manner of Death 28d. Describe how injury occurred Subject accidentally overdosed Certification: within 24 hours after deau.

To the Funeral Director: A Natural 5 Pending on pain medication FD 9/9/09 12:20 Investigation 2 X Accident 28f. Location (Street and Number of Rural Route Number, City or Town, State) 1320 Chesapeake Ave Middle River, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be determined (Specify) Residence Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 9, 2009 O.C.M.E. 11 N 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month) 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Leroy Ellerbe 8:45 P M 9 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore
Under 1 Year | If Under 24 Hrs. Joseph Richey 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days Hours Min 1 XM 2 ☐ F 6-7-1954 55 MD Director 214-62-8994 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b County ral", or items 23a or 28a-f show Examiner must be notified at Yes 2 No Director N/A MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 123 W. 29th Street Apt 14 G 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【YNo Specify. If Yes, Give Year or Dates: Specify: Black Completed by 3 Widowed 4 Divorced "natural", er than "natura", the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. 10th grade N/A <u>Disable</u>d Disabled is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Ellerbe Joyce Campbell ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Unit 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. Denise Ellerbe-Sister 3924 Rolling Road Pikesville, MD 21208 11B Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition M☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 9-12-2009 Balto, MD 21. Signature of Fun 3 Service Licensee 22. Name and Address of Facility March East F/H KIM Km MD 21202 1101 E. North Avenue Balto, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Adenocarcusma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trar Due to (or as a consequence of) 68760 Physician/Medical the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Tilnknown à σ. s been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

1 □ Yes 2 □ No page certificate Vital Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Tother (Specify) JR 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To of 28a. Date of Injury (Month, Day, Year) After thi 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation Division Injury 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 09-07-09 53275 MD

State Registrar 30. Name and address of

QUAN 31. Date filed (Month, Day, Year)

DONG

DHMH 17 Rev 1/2001

600 N.

wolfe Street

Baltimore, MD 21287

erson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NGUYEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State	State of Mary		epartment of F Certificate of a											
		Registrar 1. Decedent's Name (First, Middle, Last)						2. Date of Dea	Reg. No.	3. Time of Death							
П	Physicia	an	Willie Ma		eridge			Month Septemb	er 6, 2009	8:00 a. M							
1	/Medic Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	Location of Death		4c. County of Dear	th							
and it			5316 Sangamore R			Bethesd			Montgomet								
	Funeral Director		323-10-7037	Sex 7. Age (In ☐ M 2XXF 90	yrs, last birtl	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Aug • 2	v. Year) Co	thplace (State or Foreign ountry) Mexico								
	and	1	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits							
	Maryla -f sho icd -i	ţō	MD Montgo			Beth	esda			1 XYes 2 No							
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?							
	th with	<u>a</u>	5316 Sangamore R	d.		2083	16-2355		United Stat	tes							
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Example Involved at or other traumatic event, the Medical Example Involved at	by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - Ame Black, Whit								
5-0	72 hor	eted	15. Decedent's Ec		16a.	Decedent's Usual Occup	ation during most of work	ing	16b. Kind of Business.	/Industry							
121	within iene.	Completed	Elementary/Secondary (0-12)			Give kind of work done life. DO NOT use retired Legal Secre			Law Off	ice							
d 2	e filed within al Hygiene. I other than ' went, I'm Me	ပ္ပ	17. Father's Name (First, Middle, Last))		legal becit		e (First, Middle,	Maiden Surname)								
an	should be f and Mental s marked o' numatic eve	To Be	William	Martin			Cather	ine	Cady								
Maryland	s 1 and 2 should be of Health and Menta item 27 is marked o other traumatic ev	3	19a. Informant's Name/Relationship (David C. Etherid		1	Mailing Address (Street											
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Hemoval from State		Disposition (Name of c, crematory or other place ake Cremato	1108	. 10, 09	20c. Location - City or Beltsville	Town, State a, Maryland							
Balt	permit. Departr Importa any inju	ı	21. Signature of Funeral Service Local	hureur	0382				al & Cremateg, MD 20910	ion Service							
W. A.	Physician	8 1	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the one cause on each line.	death. Do n					Approximate Interval Between Onset and Death							
1	/Medical Examiner		resulting in death)	b. One to (or as a consequence of:						Veacs							
	ed sit	iner	Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events														
oʻ	icate be executed physician and s the burial-transit	edical Examiner	Cause (Disease of Injury that initiated events resulting in death) Last	c. Due to (or as a co	onsequence o	f):											
58760,	icate b	dica		_ d													
O. Box (ath certif attending or use as	by Physician/M	by Physician/M	by Physician/M	by Physician/M	by Physician/Me	by Physician/M	hysician/M	nysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	у		23d. Date of de Month	elivery Day Year
rds, P.	puires that the de n signed by the s ild be detached f							Part II. Other significant conditions	contributing to death but no	ot resulting in	the underlying cause giv	en in Part I.	23e. Did t	obacco use contribute t	o the cause of death? Probably 4 ☐ Unknown		
Division of Vital Records,	ding Physician: The law requires h. After this certificate has been sign funeral director, page 2 should be	Completed						24a. Was autoj perfo 1 ∐Yes	prior to death?	utopsy findings available completion of cause of							
Ζitε	stctan certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		ott	26. Place of Dea	2.4									
oţ	Physer this eral di	7. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. T	ime of 28c. Inju	4 LI Nursing H	\rightarrow	dence 6 ☐ Other (Spenow Injury occurred	ecify)							
ion	nding ath. r: Afte e fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(<i>Month, Ďay, Ye</i> n	ear) Ir		k? Yes 2 □ No										
Divis	of or Attending Physician: after death. I Director: After this certific d in by the funeral director, I	Certification: To	3 Suicide 6 Could not b 4 Homicide determined		- At home, far Specify)	m, street, factory, office		28f. Location (City or To	Street and Number or F wn, State)	dural Route Number,							
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying Pl	hysician: To the best of m miner: On the basis of ex and manner stated	amination an	, death occurred at the t d/or investigation, in my	me, date and place opinion, death occu	e, and due to the rred at the time,	cause(s) and manner a date and place, and du	as stated. e to the cause(s)							
	To the within To the Compl	Me	29b. Signature and title of certifier	01//		29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)							
			► 160 /11/1	WULL _		BK	51537	43	9-8	-09							
	6 V		30. Name and address of person who	completed cause of death		Type, Print)	St. Fall	le Color	ech VA	22046							
l	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's		hadel											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month SEPT 2009 Ye ar **Physician** 12:04 A M MATTHEW T. FLYTHE /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGES LAUREL LAUREL REGIONAL HOSPITAL Date of Birth (Month, Day, Year)
SEPT 21,1950 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Days Hours Min. 1 M 2 □ F Months **VIRGINIA** Director 58 227-78-4854 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, 11a "tedical Examina must be notified at 1 ☐ Yes 2 ☐ No WILLIAMSBURG Director JAMES CITY VA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with USA 23188 5672 CENTERVILLE ROAD Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced Specify: BLACK Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) COMMUNICATIONS WAREHOUSE SUPERVISOR FOUR filed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of Pages 1 and 2 should be ALBERTA STEPHENS JULIAN FLYTHE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 5672 CENTERVILLE RD. WILLIAMSBURG, VA 23188 NAOMI T. FLYTHE (WIFE) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) NEW ZION BAPT CH CEME 9-12-09 WILLIAMSBURG, VA 22. Name and Address of Facility WHITING'S FUNERAL HOME 21. Signature of Funeral Service Licensee 7005 POCAHONTAS TRAIL, WILLIAMSBURG, VA 23185 obert B 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of): burial Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autonsy page certificate 2 🛮 No 1 ☐ Yes 2 ☐ No 1 □Yes Division of Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2/10XNo 2 X ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To After this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: / 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide after 24 hours a Hospital 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of c ifie 9/5/09 D66945 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAUREL REGIONAL HOSPITAL EMERGENCY DEPT 10 SCOTT CARTER 7300 VAN DUSEN ROAD, LAUREL, MD 20707

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

A. Jak **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 2009 Gabriel Forbes II Aŭgüst 9:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince Georges 1 2 Hrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Vaarl Days Months 1 XI M 2 □ F Hours Director Infant 2009 Aug 27, Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ntal Hygiene. ed other than "natural", or items 23a or 28a-f shov event, the Medical Examinet must be notified at Director MD Capitol Heights 1 ☐ Yes 2 No Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 703 Painter Court 20743 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 black If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify ģ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant Infant Infant and Mental Hygi is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gabriel Forbes I Candace Griffin ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Painter Court; Capitol Heights, Maryland 20743 Candace Griffin/mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5-10ther (Specify) in state 22 Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Ronald S. Wade Director Baltimore, Maryland 21201 23a. Part 1. Enter the disease, or correlications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ocheart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARPIAC **Physician** /Medical Due to (or as a consequence of) Examiner UERE Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending use IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) the 9 Unknown δ signed ! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performa page certificate 1 □ Yes 2 2440 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 Enpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

legistrar's Signature

Year)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day September 5, **Physician** 2008 Grokulsky 8:01 Dorothy S AM /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Pasadena Anne Arundel 8374 Bodkín Ave. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 10, 1916 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 Å F Illinois 93 **Director** 321-12-0313 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Martical Eventing the street and injury or other traumatic event, I're Martical Eventing the street. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐Yes 2 HNo Md. Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 8374 Bodkin Ave. 21122 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 📉 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 ∑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Worker Oil Company 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Joseph Shileika Monica Lucas 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Polianski (Sister) 8374 Bodkin Ave. Pasadena, Md. 21122 Ruth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc.: 9/8/09 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 3111 Mountain Rd. Fasadena, Md. 21. Signature of Funeral Service Ligenses Stallings Funeral Home PA 23a. Pan 1. Enter the disease, or complications hat baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HRONIC Physician KIDNEY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Dun to (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician the dornal Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à NOIZM Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy certificate perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No **Director:** 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the within 7 29b. Signature and title of certifier 29c. License number

State Registrar 31. Date filed (Month: Day,

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

ATONSVILL

D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Tedistrar's Signature

EIP

Year)

Amend 20b, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 5 State of Maryland Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** B. Garner September 2, 2009 7:26 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Numbe 9504 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 1 M 2 K Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan obstringer of Health and Mental Hygiene. Importants if flear 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, if it is included it examiner must be notified at any injury or other traumatic event, it is inserted. 1 Yes 2 No MO Director KnHiMOVE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 833 Glenwood 21212 Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Black <u>ک</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dietician University of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cit Maryland Z1215

20c. Location - City or Town, State Hallimore uranceon 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kultimore, Maryland oudon 21. Signature of Funeral Ser Maryland 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final dan Physician Due to (or as a consequence of) disease or condition re resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Unarrying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed and Due to (or as a consequence of) burial-1 P.O. Box 68760. ending physician use as the buria Physician/Medical attending IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ▼No 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Day for Month Year 5 Other (specify) ned by the a detached for 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Division 5 Pending investigation (Month, Day, Year) 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital or within 24 hours a To the Funeral L 29a. Certifier Decritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Charles Street, Rm 3808, Baltimore, MD 21204 Saikali MD 6701 31. Date filed (Month, Day, Year) -32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GRAHAM SHIRLEY 550 AM 2009 AUGUST /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 😿 F May 25, 183-36-4998 **Director** 1945 Alabama 64 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director 1 Yes 2 No 28a-f must be notified MD Frederick Frederick 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? o 1207 C Littlebrook Drive 21702 or items 23a USA Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ Specify: 3 XWidowed 4 Divorced black "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed, the Medical 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) is marked other than College (1-4 or 5+) filed withi Hygiene. housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental F Willie Watkins Jessie Johnson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charmaine Gilliam/daughter 2912 Pamgreen Street MxKeesport, PA 15132 of Health If item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Date 20c. Location - City or Town, State 9 1 Burial 2 Cremation 3 Re Important: I any injury o 4 ☐ Donation 5 💢 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street once. Baltimore, MD 21201 Part 1 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or complicat Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) ACUTE MYELOID LEUKEMIA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, been signed by the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown Completed 1 Yes 2 No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed certificate has 1 Yes 2 X No 1 Yes 2 No eral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 2 No ၉ 3 DOA 2 ER/Outpatient 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury death. 2 Accident 1 Tes 2 | No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide after e Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 1 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 600 North Wolfe St, Baltimore, MD, 21287

MEYER

Registrar's Signature

32.

CHRISTIAN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Ye ar **Physician** GRIMM TR. NORMAN 01:59 PM September 2004 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** HARBOR HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☑ M 2 □ F Maryland 70 Director 216 26 7425 12/13/1938 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No N/A Directo Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with to ment of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or items 23a or items 23 4216 Morrison Court U.S.A. 21226 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Refinery Worker Domino Sugar vear 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Norman Clarence Grimm Sr. Dolores Elizabeth Fitzhugh ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Mooney / Daughter 4216 Morrison Court Baltimore, Maryland 21226 permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 09/11/2009 Baltimore, Maryland Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signatore of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a bart 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** DIFFICILE PANCOLITIS ClosTRIDIUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown INFECTED ISCHEMIA RIGHT FAILURE 24b. Were autopsy findings available prior to completion of cause of death? RENAL 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hnpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending ours after death.

neral Director; A
filled in by the fu death. investigation 1 Tes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD September-05-2009 Mals davig RES-001

Saltimore, Maryland 21215-0036

Box 68760,

P.O.

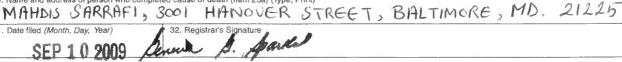
Records,

of Vital

Division

State Registrar

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		For	State of	Marylan		artment of H		and Me	ntal Hyg	jiene		
	_	1 - State Registrar			Cei	rtificate of I	Death			eg. No.	110	28831
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Examin		4a. Facility Name (If not institution, give	street and num	ber)		4b. City, Town, or	Location of	of Death		4c. County of		
		1009 Jack Place					timo			N/A		
Funeral Director		211-30-121-	X	7. Age (In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. 8	Date of Birth (Month, Day,	Year) ()	Coun	ace (State or Foreign try) ginia
and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation			· ·	·	11	Od. Inside City Limits
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r dea	Funeral	11. Marital Status	12. Was Deced Armed Ford	ces?	S. 13.\	Was Decedent of H	ispanic Ori an, Mexicar	igin? (Speci n, Puerto Ric	y Yes or No- can, etc.)	14. Race Black,	- Americ White, e	
72 hours after death with the Maryland ratural", or Items 23a or 28a-f show dical Examinat he notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 If Yes, Give Year or Dat	9	- 1	1 □Yes 2 No	Specify:			Specify:		ite
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be file	Be	17. Father's Name (First, Middle, Last)	larence	ĭ.ĭ_ ∴ £	J					Maiden Surname,)	
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id 2 sl Ith an 27 is r traur		19a. Informant's Name/Relationship (7) Edward Gollahon /	Son			ng Address (Street Jack Pla				, chy or rown, s Marylan		•
f Hea	-	20a. Method of Disposition	5011	20b. P		sition (Name of natory or other place		Dare		20c. Location - C		
Pages ment of l ant: If Ite		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,		late		natory or other place crematory		09/04/	2009	Baltimo:	re, l	Maryland
permit. Departir Importa any Inju		21. Signature of Funeral Service Licens		Day		2. Name and Addre	ss of Facilit	ty Gonce	Funer	al Servi	ice,	P.A.
89 5 88		Dania Man	ener	ousli		01 Ritch:						
		234. Part1. Enter the disease, mp shock, or heart failure. Lie nly o	lications that ca ne cause on ea	used the death ch line.	n. Do not ent	er the mode of dyir	ng, such as	cardiac or r	espiratory arr	rest,		Approximate Interval Between
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aath c attenc for us	Physician/Me	23b. Was decedent pregnant in the past 12 mopths?		rth 2 Feta	death 3	Ectopic pregnanc	у			23d. Date Mont		ry Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unkno	ant at time of d wn	eath 5L	Other (specify) _						
Attending Physician: The law requires that the death certifucath. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as		Part II. Other significant conditions co	-	- Common	-		en in Part I		23e. Did tol	bacco use contrit	ute to th	e cause of death?
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ding I	<u></u>	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of (Month	r Injury n, <i>Day</i> , Year)	28b. Time of Injury	Worl	yat k? Yes 2□		d. Describe ho	ow injury occurred	d	
Atten deatl ctor: y the	lical	3 ☐ Suicide 6 ☐ Could not be	28e. Place o	of Injury - At ho	me, farm, str	eet, factory, office	162 2		Location (S	treet and Number	or Rura	l Route Number.
al or / s after il Dire	Certification:	4 Homicide	building	g, etc.*(<i>Specif</i>)	()				City or Towi	n, State)		,
	<u>a</u>	29a. Certifier Certifying Phy	rsician: To the b	pest of my kno sis of examina	wledge, deatl tion and/or in	h occurred at the till vestigation, in my o	me, date ai	nd place, an ath occurred	d due to the c at the time, d	cause(s) and mar late and place, ar	ner as s	tated. the cause(s)
orthe omple	Mec	29b. Signature and title of certifier	and manne	er stateu.		29c. Licens	e number		2	29d. Date signed	(Month,	Day, Year)
F S F O		1 Law	-P	MD		7-	005	722	0)	081	21/	2009
		29b. Signature and title of certifier 30. Name and address of person who ce 31. Date filed (Month, Day, Year) SEP 10 2009	ompleted cause	of death (Item	23a) (Type,	Print)	1 2	1010	R S	TREF	11	MEMD
Stat	е	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ture		177		, ,		100	- , - ,
Registra	ır	SEL TO SOUR	Lenny	J F. "	A COUNTER							

Amend #1, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra 883 Certificate of Death 1. Decedent's Name (First, Middle, Last) Jacob A.K.A. Jankiel Gold 2. Date of Death 3. Time of Death SEPT. **Physician** 2009 4, 7:46 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13 COLUMBINE COURT BALTIMORE BALTIMORE 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 87 Yrs. 8. Date of Birth 03/17/1922 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. **Funeral** Days Hours 216-32-4065 POLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD BALTIMORE BALTIMORE or 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13 COLUMBINE COURT 21209 USA Funeral filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: WHITE Baltimore, Marvland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) i and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) OWNER FOOD MART Market Father's Name (First, Middle, Last) GERSHON 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Inportant: If Item 27 is marked oth any linjury or other traumatic event one. Be GOLD SHAIVA LANDSMAN ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LOUISE GOLD / WIFE 13 COLUMBINE COURT BALTIMORE, MD 21209 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM. 09/06/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest an each line. shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) **Physician** doles /Medical as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed entension and P.O. Box 68760 by Physician/Medical use as t IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 2 No certificate 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu neral Director: / investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number me and address of person who completed cause of death (Item 23a) (Type, Print) durence mon mi) 31. Date filed (Month, Day, Registrar's Signature State

Registrar

SEP 1 0 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 **Physician** SEPTEMBER **JEANETTE** N 2009 5:18 P GOLDSTEIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2 JOANNA COURT BALTIMORE BALTIMORE Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) 08/19/1921 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 ី F 220-07-1197 88 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f show MD BALTIMORE 1 ☐ Yes 2 X No Director BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examines must be not any injury or other traumatic event, the Medical Examines must be not any injury or other traumatic event, the Medical Examines must be not approximate the second of the contraction of the contracti Funeral USA 2 JOANNA COURT 21208 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∏Yes 2 MX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: WHITE <u>ک</u> Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SALES RETAIL 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) **JACOB** ဂ္ NEEDLE LENA COHN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SCOTT GOLDSTEIN / SON 11960 LONG LAKE DRIVE, REISTERSTOWN, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ARLINGTON CHIZUK AMUNQO9/06/2009 BALTIMORE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Days to (or as a nonsequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 5 Other (specify) ed by the a 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 2 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) Assistant Protessor 005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV 31. Date filed (N State Registrar

For	State of Maryland / Department of Health and Mental Hygiene												
State Registrar	Co	ertificate of Death	Reg. No.										
Decedent's Name (First, Middle, Last)	1 0		ate of Death Ionth Day Year	3. Time of Death									

Physician /Medical Examiner

Funeral

Director ir than "natural", or items 23a or 28a-f show the Medical Experimentmust be notified at al Hygiene.

Box 68760, P.O. of Vital Records,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 7907 Elizabeth Road 21122 Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 D No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3√ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Meat Cutter of Health and Mental Hygie I Item 27 Is marked other Ir other traumatic event, II 17. Father's Name (First, Middle, Last) John Hauhn Sr. Sophie ျှ 19a. Informant's Name/Relationship (Type. Print) Henry J. Hauhn Jr. permit. Pages 1 and Department of Healt Important: If item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Sept. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 21. Signature of Furleyal Service Lig 22. Name and Address of Facility Part . Enter the chease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail re. List of the chase on each line. 23a. Pan . Enter the Immediate Cause (Final disease or condition resulting in death) Advanced **Physician** Senile Dementia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or se a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Physician/Medical the 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š VBease Be Completed 24a. Was an autopsy performed 1 □Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Division 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier D52544 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Benjamin

Hauhn Henry Sr. Sept. 03 2009 09:55 AM 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Oak Lodge Assisted Living Pasadena If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 → M 2 □ F Months Days Hours Min. 89 Yrs. 1920 MD May 10 218-03-4926 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2 ☐ No 10g, Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Retail Grocery 18. Mother's Name (First, Middle, Maiden Surname) Dessauer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7907 Elizabeth Road, Pasadena, MD 21122 20c. Location - City or Town, State Baltimore, Maryland Stallings Funeral Home, 3111 Moiuntain Road, Pasadena, MD 21122 Approximate Interval Between Onset and Death 4eats 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

100 Geipe Rd #204, Catonsville, MD 21228 32. Registrar's Signature

31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 1445 Ам Recie Hatfield

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Modical Examinar must be notified at once. Baltimore, Maryland 21215-0036

Physician

/Medica Examine

Funeral Director

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executi within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

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	4a. Facility Name (If not institution, give	e street and number)		4b.	City, Town, o	r Location of Deat I ₽	South orc			
	5. Social Security N	lumber 6. S		e (In yrs. last birth	Mo	Under 1 Year onths Days	If Under 24 Hrs Hours Min.				thplace (State or Foreign ountry)
7	234-28-1 Usual Residence o	5/5	□м 2/СГ 8	/ Y	rs.	July Buyo	Tiodio IIIII	3-15-		UN	
-	10a. State	10b. County		10c. City, Town	or Locatio	in /					10d. Inside City Limits
	MD	Baltime	ore	Ĺ	IN	Κ.					1 □Yes 2 📉 No
	10e. Street and Nu		_			0f. Zip Code			10g. Cit	tizen of What C	ountry?
		dge Roa	1			21237	ilanania Oriaia (2it. V av N		USA	
	11. Marital Status 1 XNever Marr	ried 2 Married	12. Was Decedent : Armed Forces? 1 □Yes 2 🕅 !				lispanic Origin? (an, Mexican, Puer	to Rican, etc.)	0-	14. Race - Am Black, Whit	e, etc.
	3 🗆 Widowed		If Yes, Give Year or Dates:		1 🗆 \	∕es 21⊾No	Specify:			Specify: Wh	ite
9	(Spec	15. Decedent's Ed cify only highest gra	lucation ide completed)	16a. I	Decedent'	of work done	ation during most of wo d)	rking	16b. K	ind of Business	/Industry
	Elementary/Seco	ondary (0-12)	College (1-4or 5	+)	nie. do r NK	iOT use retire	2)			UNK	
		(First, Middle, Last)	UNK		2121		18. Mother's Na	me (First, Middle	, Maiden	Surname)	
	UNK						UNK				
		ame/Relationship (s Prayeb.					ber, City o	or Town, State,	Zip Code)
-	20a. Method of Dis	ent Of A	Aging				l Ave.	Towson		204 ocation - City or	Town State
	1 Burial 2		Removal from State	20b. Place of the cemetery Mt. C	, crematoi			26/09	ł	timore	
	21. Signature of Fa	uneral Service Licer	Plan 1-	Q ₁		me and Addre	uneral			Hudso	
Ì	23a. Part 1. Enter t	the disease, or comp	plications that caused one cause on each lir	he death. Do no				<u>D</u>	arrest,	imore	21224 Approximate Interval Between
1	Immediate Cause disease or condition	(Final	ACTIFE V	esoivato	UL FO	illiant					Onset and Death
	resulting in death)		Due to (or as	a core equence of	-						
	Sequentially list ou	riditions, 6	b. YHUMO	a consequence of	N -						
,	Sequentially list out if any, leading to im- cause. Enter Under Cause (Disease or	erlying	Due to (0) as	a consequence of	7.						
	that initiated events resulting in death)	Last	Due to (or as	a consequence of	f):						
			d								
-	IF FEMALE:		23c. If yes, outcome	of pregnancy					- 1	and Data of de	I I I I I I I I I I I I I I I I I I I
	23b. Was deceden in the past 12 1 Yes 2	months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death		topic pregnant ner <i>(specify)</i> _				23d. Date of de Month	Day Year
	9 Unknown		9 ☐ Unknown								
	Part II. Other signi	ficant conditions o	ontributing to death be	ut not resulting in t	the underl	ying cause giv	en in Part I.				o the cause of death?
									260	A	Probably 4 🔀 Unknown
-								24a. Was	psv	prior to	utopsy findings available completion of cause of
1	25. Was case refer	red to medical					26 Place of Do	1 ☐ Yes	ormed? 2 🗓 No	1 □Ye	s 2 🗷 No
	examiner? 1 ☐ Yes 2 🔀		Hospital: 1 X Inpatie	ent 2 🗆 ER/Out	patient 3	□ DOA Oth	or.	Home 5 ☐ Res		6 ☐Other (Spi	ecify)
1	27, Manner of Deat	th 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Ti	jury	28c. Inju Wor		28d. Describe			
	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be		and Atheres (V 1 □	Yes 2 □ No	206 1*	(04		Don't Marie
	4 ☐ Homicide	determined	building, et	ury - At home, farr c. <i>(Specify)</i>	n, střeet, i	actory, Office		28f. Location City or To	(Street al wn, State	na Number or F e)	ural Route Number,
	29a. Certifier (Check only one)	1 M Certifying Ph 2 Medical Exam	nysician: To the best niner: On the basis o and manner sta	examination and	death oco l/or investi	curred at the ti gation, in my	me, date and place opinion, death occ	e, and due to the curred at the time	e cause(s , date an	s) and manner and place, and du	as stated. e to the cause(s)
	29b. Signature and	title of certifier				29c. Licens	8 6 9 4		29d. Da	ate signed (Mon	th, Day, Year)
	30. Name and addi	ress of person who	completed cause of d	1 0	- 7) -		140		727	4
	31. Date filed (Mon	oth, Day, Year)	000 trank	ar's Signature	are 1)rire	Dallim	ore MD	121	LOT	
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State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 7,2009 **Physician** 3:34 PM Housewright Mildred J. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2X F June 22,1923 Missouri 86 489-20-8380 **Director** Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be mailibled at 10a. State 1 XYes 2 □ No Director Annapolis Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe USA21409 85 Manresa Road, #330 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Black, White, etc 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No If Yes. Give Completed by 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) <u>Research Specialist</u> UFCW permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 Is marked other than any injury or other treasment. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessie Jack Tillman R. Shults 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 101 Nanthala Ct. West, Hertford, North Carolina Linda Nostheide/Daughter 20c. Location - City or Town, State 27944 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia Columbia Gardens Cem 9/12/09 22. Name and Address of Facility Money & King Funeral Home, Inc. 21. Signature of Funeral Service Cicensee Gary Downer 171 W. Maple Ave., Vienna, Va. 22180 JUM CCO 508 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnan in the past 12 months? 3 Ectopic pregnancy Day Month 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 10 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 | NO 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No **≱** Inpatient 28d. Describe how injury occurred 28b. Time of 27. Manner Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 5 Pending investigation 1 tural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certific 0 MY 30. Name

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

09-06677 Noah Holloman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oah Holloman		State of Maryland / Department of Health and Ment -For State Certificate of Death	tal Hyg		eg. No.	110 2023
Physician		egistrar 1. Decedent's Name (First, Middle,Last)		Date of Dea Month	Day Year	3. Time of Death
ledical Examin	er	Noah Daniel Holloman		August 26	4c. County of De	1124 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Smithsburg	of Death		Washingtor	· ·
	ą,	21021 001101011 200101010	er 24Hrs.	8. Date of Bit	th(MM/DD/YYYY) 9.	
Funeral		Months Days Hours			, 1963 Fo	country) Virginia
Director		228-13-2706 1 XM 2 F 46 Yrs. Sey		Api i	, 1505	
any		Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County				10d. Inside City Limits
*		Maryland Washington Smithsburg				1 Yes 2 X No
Aaryland 28a-f show I at once.	왌	10e. Street and Number 10f. Zip Code		1	l0g. Citizen of What	Country?
th the Mary	Director	21821 Jefferson Blvd 21783			USA	
		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Marital Status	gin? (Spec	cify Yes or No	14. Race - A White, e	merican Indian, Black, cc.
death or iter	Funeral	Never Married 2 Married 1 Yes 2X No		,	S-coif.	1411 21
raffer	ᇫ	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give		ork done	Specify:	White ess/Industry
hours 'natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give during most of working life. DO NOT	use retire	ed)		
36 in 72 than t	ble	General Manager			Equipme	nt Company
5-0036 iled within 7 Hygiene. I other than the Medica	Completed	17. Father's Name (First, Middle, Last) 18. Mother	er's Name (First, Middle,	Maiden Surname)	
215 215 oe file ntal H. ked o	8	IICIII V I I IICIICIII ai.	y Sue	e Goeb	oel	
MD 21215-0036 2 should be filed within 72 hours after h and Mental Hygiene. 27 is marked other than "natural", or matic event, the Medical Examiner.	2	19a. Informant's Name/Relationship (Type, Print)				
nore, MD 21215-0036 spes I and 2 should be filed within 72 nt of Health and Mental Hygiene. Firem 27 is marked other than other traumatic event, the Medical		Henry F. Holloman/Father 10714 Norman Av.	e.,Fo	Date	20c, Location - Ci	ty or Town, State
altimore, mit. Pages 1 ar partment of Hee portant: If ite	- 1	1 X Burial 2 Cremation 3 Removal from State crematory or other place)				
Page ment tant:		4 Donation 5 Other Specify: Damascus Cemetery	9/2	/2009_	Fulton C	ounty, Pa.
Baltimo permit. Page: Department o Important: injury or oth		21. Signar re of Funeral Serva Licensee Cary Down & Name and Address of Facility Money & King CC0508 171 W. Maple	Fune	eral, H	ome, Inc,	22100
	\dashv	23â. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as of	cardiac or	respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
Physician Medical	-	failure. List only one cause on each line.				Death
raminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	asc			
2 -		Sequentially list conditions, b				
	iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
_	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
OX 68760, ath certificate be executed attending physician and or use as the burial - transil		d. AMENDED 23a,27,perME g895 9/11/09	TT			
), be exi	dical				23d. Date of d	eliven
68760 certificate ading phys	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectop	pic pregna	ncy	Month	Day Year
K 68	ciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			4	19
Box e death c the atten	hysi	1 Yes 2 No 9 Unknown g Unknown	D- (I	1220 Die	tobacco use contrib	ute to the cause of death?
P.O. es that the igned by be detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F	Рап I.			Probably 4 🗸 Unknown
S, P				24a. W	as an 24b. W	ere autopsy findings available
ords, aw requir has been s	Completed					or to completion of cause of eath?
Rec The Is cate h	No.				s 2 No 1	Yes 2 No
Vital Rec ysician: The his certificate director, page	Be (25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4		only one)	Residence 6 ✓	Other: Scene
of Vid g Physic fter this	2	1 ✓ Yes 2 No I inpatient 2 Ervoupatient 3 Box			be how injury occurre	
nonding h. Afte	ion:	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Wo	No			
Division of Vital Records, tal or attending Physician: The law requirt is after cleath. al Director: After this certificate has been sited in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	icat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building,	, etc.	28f. Locatio	n (Street and Numbe	r or Rural Route Number, City
Division of 'pital or Attending Phours after death. Peral Director: After titled in by the funeral	Certification:	3 Suicide 6 Could not be determined (Specify)		or I owi	n, State)	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and	place, and	due to the c	ause(s) and manner	as stated.
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.		at the time, di		
F # F ö	ž	29b. Signature and title of certifier 29c. License numb	per		August 27,	d (Month, Day, Year)
		Calment (O.C.M.E.			/\togust 21,	
		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21	1201		
S [.] Regis	tate					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Marylar		artment of I <i>rtificate of</i>			ene g. No. 2		28837
			Decedent's Name (First, Middle, Last)					2. Date of Death	1		3. Time of Death
	Physicia		Freda Alme	da Harry				Sept.		rear 09	1:00am
	/Medic Examin		4a. Facility Name (If not institution, give st	treet and number)		4b. City, Town, o	r Location of Death	-	4c. County of	Death	
!			2901 Southbro	ok Road	10	Dui	ndalk		Balt	imo	re
П	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days		8. Date of Birth (Month, Day, Feb. 9	1 9	9. Birthp Coun	ace (State or Foreign trv)
	Director		230-30-0073	W 2LAF	82 Yrs.			Feb.9,	1927		WVA
	and **		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10	Od. Inside City Limits
	Mary f sho	to	MD Baltimo	re	D	undalk					1 □ Yes 2√ No
	r 28a	irec	10e. Street and Number			10f. Zip Code		10	ng. Citizen of Wh	nat Coun	try?
	h with	ai D	2901 Southbroo	k Road		212	22		US	SA	
	or death with the Marylan items 23a or 28a-f show or institution at	Funeral Director	11. Marital Status	Was Decedent Ever in U Armed Forces?	l.S. 13.	Was Decedent of I	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race Black	- Americ White, e	
Š	after or it		1 Never Married 2 Married	1 ∐Yes 2x No IfYes, Give		1∐Yes 2⊠No			Specify:		
215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show freed Everities or used by confilled at	d by	3X Widowed 4 □ Divorced	Year or Dates:	16a Dass	dent's Usual Occu	nation	T .	16b. Kind of Bus		
င်	n 72 i "nat	olete	15. Decedent's Educa (Specify only highest grade	completed)	1 (Give	kind of work done DO NOT use retire	during most of work		TOD. KING OF DUS	111655/1110	iusti y
717	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12) 7th	College (1-4or 5+)	Ste	eamstre	ss		Hoope	er &	Sons
0		Ø.	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, M	laiden Surname)	
/land	uld be Mental irked o	To B	Abraham Haw	ks			Lela M	McLough:	lin		
Mary	2 should be and Menta is marked aumatic ev		19a. Informant's Name/Relationship (Typ		1	-	t and Number or Ru				
≥,	and lealth m 27 her tr		Patty Warrenfel				hbrook E				
<u> </u>	ges 1 ht of H iffite or ot		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re			sition (Name of matory or other pla			20c. Location - C	•	
saitimore,	it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Specify)	_			ery 9/1	_	Baltimo		
g	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licens	markel			ess of Facility 3(y Funera				
	_		23a. Par 1. Enter the disease Complic	cations that caused the dea						SEA	Approximate
	Dhysisian	9 7	shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.	O.	IE	ilure			1	Interval Between Onset and Death
No.	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	guence of):	151	ilure			1,	-2 years
- Andrew	Examiner			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	quence of):						
6.	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		-0						
8760,	icate be executed physician and the burial-transit		resulting in deathy East	Due to (or as a consec	quence oi):						
200	physicate the b	dical	d.								
×	death certif e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregr					23d. Date	of delive	erv
ROX	atter for L	ciar	in the past 12 months? 1 □ Yes 2 ■ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of		☐ Ectopic pregnan ☐ Other <i>(specify)</i> _	су		Mon		Day Year
o.	t the c by the achec	hysi	9 Unknown	9 Unknown							
ري ح	w requires that the death certific been signed by the attending I should be detached for use as	by P	Part II. Other significant conditions cont	tributing to death but not re	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did tob	acco use contri	bute to th	ne cause of death?
Records,	en sig		<u>Dementia</u>					1 □ Ye	s 2 No	3 Prot	pably 4 Unknown
ပ္ထ	B 86 C1	Completed	Hypertension					24a. Was a	n 24b. W	ere auto	psy findings available mpletion of cause of
_	T age	Son	Kidnay Ston	Le.S				perforr 1 □ Yes 2	ned? de	eath? □Yes	
Vital	ician: The certificate rector, pag	Be (25. Was case referred to medical			100		ath (Check only on	e)		
0	Physic this cal dire	2	TE Tes ZIA(NO	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatie	III 3 LI DOA		lome 5 Reside		· ,	(y)
ב	tending Physician: leath. tor: After this certific the funeral director,	ion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Wo	rk?]Yes 2□No	28d. Describe ho	w injury occurre	a	
DIVISION	Attendestification description of the year.	fica	3 Suicide 6 Could not be	28e. Place of Injury - At I	nome, farm, str		1100 2 2 110	28f. Location (St	reet and Numbe	r or Rum	al Route Number,
\leq	afor / s after Dire	Certification:	4 Homicide determined	building, etc. (Spec	ify)			City or Towr	i, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, it			.ician: To the best of my kr ner: On the basis of examir							
	the H hin 24 the F nplete	Medical	one)	and manner stated.	orr aria/or II						
	S N With	2	29b. Signature and title of certifier	100			se number	2	9d. Date signed		
	*		Well NY	ello	00 : =		55992		09/00	9/0	9
ij.	3		30. Name and address of person who cor				Baltin	MC MC	7.1227)	
ľ	Sta	te	31. Date filed (Month, Day, Year)	37 Registrar's Sign		pires 11Ve	214 (1)n	110	0100		
			SEP 1 0 2000		K /						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#IperPHYS#5perFH G895, 9/28/09 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 09,2009 10:55AM **Physician** Harvey E. Henry Harvey E. Henry, III /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore County Timonium 121 Oakway Road 9. Birthplace (State or Foreign Country) | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 25,1926 . 200 Security Number 7. Age (In yrs. last birthday) **Funeral** Months Maryland 1 AM 2□ F 80 Yrs -218-26-7809 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 10a. State ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 🛣 No Director Maryland Baltimore County Timonium 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21093 United States 121 Oakway Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 11. Marital Status Yes 2 No 1 ☐ Never Married 2 Married If Yes, Give 1952-54 Year or Dates: 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Fire Department Fire Fighter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any liquy or other traumatic event once. Be Priscilla Carver Harvey Henry ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Timonium, Maryland 21093 121 Oakway Road (Wife) Betty Henry 20c. Location - City or Town, State Sept. 12, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1. Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 2009 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part / El ter n'e : seas / dr complestions that caused the death. sho k, /r he int f lure/ List only one cause in each line. Immediate ause (Fin I disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b Was decedent pregnant 3 🗌 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Qid tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 🗆 Yes 1 ☐ Yes certificate 26. Place of Death (Check only one, 25. Was case referred to medical filled in by the funeral director, Be examiner? Desidence 6 ☐ Other (Specify) Other: 4 \(\sum \) Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred 27. Manner of Death
12 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 5 Pending 1 ☐ Yes 2 ☐ No after death. investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical соmpletely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

10 11

State
Registrar

30. Name and address of person who completed ca

32. Pogistrar's Signature S. Sans

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Value of Print in Black Indelible Ink. Ensure All Copies Are Legible.

UNK UNK	1-	State of State / Department For State Certificate	t of Health and e of Death	Mental I	Reg. No	000	10 2004
Diam'r i sina	Re	gistrar Decedent's Name (First, Middle,Last)		2.	Date of Death	tion to	3. Time of Death
Physician Medical Examine	**	Chris D. Hester			Month Day September 1,	2009	0245 hrs
1		a. Facility Name (if not institution, give street and number)	4b. City, Town, or I Baltimore	ocation of Death	4	c. County of Death	
		University Hospital		If Under 24Hrs.	8. Date of Birth (MN	//DD/YYYY) 9. Birt	hplace (State or
Funeral	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days	Hours Min.	Jan. 11	, 19 Toreig	MLD)
Director	L	212-01 0000 I_AM 2F	Yrs.	1			
any	_	sual Residence of Decedent 0a. State 10b. County 10c. City, Town or L	Location altimore				10d. Inside City Limits 1 Yes 2 No
<u> </u>	_ N	Maryland N/A			140 0	itizen of What Cou	
farylai	Director	0e. Street and Number 2nd fl	loor 21	216	US		nuy:
rith the Maryland 23a or 28a-f show a notified at once		3036 Belmont Avenue	3. Was Decedent of His		cify Yes or No-	14. Race - Amer	ican Indian, Black,
th with		Never Married 2 Married Armed Forces?	If Yes, specify Cubar	, Mexican, Puerto R	ican, etc.)	White, etc.	ak
er dea		Widowed 4 X Divorced If Yes, Give Year	1 Yes 2 X No			Specify:	
"natural", Examiner	핡	Tor Dates:	cedent's Usual Occupa	tion (Give kind of wo		. Kind of Business/	Industry
72 ho	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	me Improv			Self Emp	oloyed
DO3(within iene.	Completed	12th grade Hor		18.Mother's Name (First, Middle, Maid	en Surname)	
21215-0036 uld be filed within 72 Mental Hygiene. marked other than cevent, the Medical	Be	Hubert Hester, Jr.			a A. Ba		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	밁	19a Informant's Name/Relationship (Type, Print)	Mailing Address (Stre	et and Number or Ru	ural Route Number	, City or Town, Stat	e, Zip Code) 21216
MD 12 shc 12 shc 127 is		Increba ne medett,	Disposition (Name of ce		Date 20	c. Location - City c	r Town, State
rre, s 1 and freal of Heal		cremators	y or other place) mount Cen	1 4/	11/00	altimore	e,Maryland
imo Page ment c		4 Donation 5 Other Specify:					uneralHome
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr	- 1	21. Signature of Funeral Service Utensee	5240 Reis	sterstow	n Rd Ba	ltimore	,MD 21215
Physician	1	23d. Part I. Enter the disease, or complete line.	enter the mode of dying	g, such as cardiac or	respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical	1	failure. List only one cause on each line. Immediate Cause (Final disease a. Gunshot wounds (2) to the he					Death
aminer		or condition resulting in death) Due to (or as a consequence of):					
	<u>-</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	Examiner	(Disease or injury that initiated					-3
cuted mind transit	Exa	events resulting in death) Last Due to (or as a consequence or).					
0 "	edical	UNPENDED AMENDED					
	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		Ectonic progns	ancy	23d. Date of deliv Month	ery Day Y ear
Records, P.O. Box 68760 The law requires that the death certificate I icate has been signed by the attending phys page 2 should be detached for use as the br	ian/M	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Pregnant at time of death 5	T etal death	Ectopic pregna	incy		,
Sox death of e atter I for us	ysici	1 Yes 2 No 9 Unknown g Unknown			les pittel	una contribute	to the cause of death?
O. E at the c 11 by th	y Phy	Part II. Other significant conditions contributing to death but not resulting	in the underlying caus	e given in Part I.		2 ✓ No 3 F	
tal Records, P.O. B cian: The law requires that the d certificate has been signed by the ector, page 2 should be detached	d by				24a. Was ar	1 24b. Were	autopsy findings available
ords w requisited been should	Completed				autops) perform	prior death	
Reco	mo:			I Decite (Observe	1 Y Yes 2	No 1 🗸	Yes 2 No
Vital Recystician: The list certificate I	Bec	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✔ ER/Out		Other Nursi		tesidence 6 O	ther:
is si di	2	1 ✓ Yes 2 No		njury at Work?	28d. Describe ho	ow injury occurred	
	io i	1 Natural 5 Pending Sep 1, 2009 Year) 0057	7 hrs 1	Yes 2 ✔ No	Subject shot		
	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	arm, street, factory, offic	ce building, etc.	28f. Location (St or Town, St	reet and Number o ate) in Street, Baltimo	r Rural Route Number, City
Divisi Divisi Sepital or Att hours after d meral Direct y filled in by	j j	determined (Specify) Local Street					
Hos Hos		29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in the basis of examination and/o	ath occurred at the time	e, date and place, an nion, death occurred	d due to the cause at the time, date a	i(s) and manner as ind place, and due	stated. to the cause(s)
To the Hos within 24 h	Medical	and marrier stated.		ense number		29d. Date signed	(Month, Day, Year)
	Σ	29b. Signature and title of certifier		.C.M.E.		September 1,	2009
		30. Name and address of person who compreted cause of death (Item 23a)					
		Zabiullah Ali, M.D. Assistant Medical Examiner 1	11 Penn Street, E	Baltimore, MD 2	1201		
	i	31. Date filed (Month, Day, Year) 32. Registrar's Signature	backer				
Regis	stra	CEP 1 0 2009 Chrone B.	· KAP CALL				

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mar		epartment of F Certificate of		ına ivlen		grerre Reg. No.	J <u>G</u>	3 1 8 4 1)
L			1. Decedent's Name (First, Middle, La	ast)					Date of Dea			3. Time of Death
	Physicia /Medic		Karen Marie Hop	pe					Month Sept	ember 5,	ear 2009	6:00 AMM
Barn	Examin		4a. Facility Name (If not institution, gi			4b. City, Town, o	r Location of	f Death		4c. County of		
			Holy Cross Hosp	ital			Silve	er Spr	ing	Montg	omer	J
	Funeral				In yrs. last birth	day) If Under 1 Year Months Days		24 Hrs. 8. [h 9		ce (State or Foreign
	Director		548-43-0275	1 □ M 2 🗹 F	47	rs.	Tiours					fornia
	pu ,		Usual Residence of Decedent		0 0 T						104	Incide City Limite
	shov	_	10a. State 10b. County	1	0c. City, Town	or Location					100	. Inside City Limits 1 ☐ Yes 2 🔀 No
	Ba-f	Director	MD Montg	omery	Silve	r Spring						
	ift tf	Ë	10e. Street and Number			10f. Zip Code				10g. Citizen of Wha	at Country	/?
	s 23a	<u>ra</u>	10019 Pratt Plac	1		20910				United		
	tems	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?		 Was Decedent of F If Yes, specify Cub: 	lispanic Orig an, Mexican,	gin? (Specify , Puerto Rica	Yes or No- in, etc.)	14. Race - Black,	American White, etc	
36	s afte	by F	1 ☑ Never Married 2 ☐ Married	1 □Yes 2 No If Yes, Give		1 ☐ Yes 2 🔼 No	Specify:			Specify:		
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show deat Examilyari sast burn tiffed at	ळ	3 Widowed 4 Divorced	Year or Dates:	160	Decedent's Usual Occup	nation			16b. Kind of Busir		ite
5	n 72	Completed	15. Decedent's E (Specify only highest gi	ade completed)	(Give kind of work done life. DO NOT use retired	during most (d)	of working		TOD. KING OF BUSIN	1655/111003	on y
12	withi ene. than	m C	Elementary/Secondary (0-12)	College (1-4or 5+)	_		_,			Travel	Acon	CNZ
0	filed Hygi ther ent,		17. Father's Name (First, Middle, Las	t)	1	gent	18. Mother	r's Name (Fir	rst, Middle,	Maiden Surname)	ngen	<u></u>
an	d be ental ked c	o Be	Harold D. Hoppe				Line	da Sai	ndblom	n.		
<u></u>	should mari	၉	19a. Informant's Name/Relationship	(Type, Print)	19b.	Mailing Address (Street					ate. Zip C	ode)
Maryland	id 2 s Ith ar 27 is 1 trau		Robin Diorio /F:		1	96 Azure H						*
ē,	1 an Hea tern 2		20a. Method of Disposition			Disposition (Name of crematory or other place		Date	71111	20c. Location - Ci		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If the Zi is marked other than." natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expression 1 and the retified at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec						09,	Beltsvil	110 1	Manufamak
≢	artme ortan injur	1	21. Signature of Funeral Service Lice		_	peake Crema		200	19	Bertsvi.	Lie, i	Maryrand
æ	Dermi Depa Impo any it	1	W 4-1. (1) 41	mann	0382	Rapp Fune	ral &	Cremat:		ervices Maryland	2091	0
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused th	e death. Do no						A Ir	pproximate nterval Between
4	Physician		Immediate Cause (Final disease or condition			ANCER					C	Onset and Death
	/Medical		resulting in death)	Due to (or as a d								
	Examiner		Sequentially list conditions	b								
	P #	<u>a</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a d	consequence of):						
	and -trans	Examiner	that initiated events resulting in death) Last	C		N.						
90,	be ex	Ē	recounting in accurate participation	Due to (or as a d	consequence of);						
68760,	ificate be executed physician and is the burial-transit	edical		d							_	
9 ×	ding page as	₩	IF FEMALE:	220 If you outcome of	progponov							
Box	eath certifi attending for use as	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal death	3 Ectopic pregnand	у			23d. Date of Month		ay Year
o.	the a	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown	me or death	5 ☐ Other (specify) _						
σ.	that the de ned by the detached		Part II. Other significant conditions	contributing to death but	not resulting in t	the underlying cause giv	en in Part I.		23e. Did to	obacco use contrib	ute to the	cause of death?
ds,	e igi e	<u>a</u>				yg y			1 🗆 ۱		☐ Probab	
Š	requ	Completed						— -				
န္တ	e law has je 2 s	ם							24a. Was	osy prio	ere autops or to comp ath?	y findings available bletion of cause of
_ 	r: Th icate r, pag								1 ☐ Yes		Yes 2	□No
Ë	hysician: The k his certificate ha I director, page 2	8	25. Was case referred to medical examiner?	Hospital:		Oth		of Death (CI				
5	Phys this al dit	은	1 ☐ Yes 2 No 27. Manner of Death	1 Inpatient 28a. Date of Injury	2 ER/Outp	Datient 3 LI DOA				dence 6 Other	(Specify)	-
E C	Jing After funer	<u>.</u>	1 Natural 5 ☐ Pending	(Month, Day,)		ury Wor	ryan rk?]Yes 2.∐N		Describe r	now injury occurred		
<u></u>	ttend death stor: / the	Cal	Accident investigation 3 □ Suicide 6 □ Could not I	De 28e Place of Injury	At home fare	m, street, factory, office		1	Location (Street and Number	or Pumili	Pouto Number
Division of Vital Records,	or A after Direc	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)	ii, street, factory, office		201.	City or Tov	vn, State)	or nurai r	noute ivainber,
_	spital ours neral filled		29a. Certifier	hysician: To the best of	mv knowledge.	death occurred at the ti	ime, date and	d place, and	due to the	cause(s) and mani	ner as sta	ted.
)	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, p.	edical		miner: On the basis of e and manner state	xamination and							
)	To th Withir To th	Z	29b. Signature and title of certifler	177.		29c. Licens	se number			29d. Date signed (Month, Da	ay, Year)
			• (X \/	MMM	XVL/	D/	357	9		9-5	- 21	309
		1	30. Name and address of ler on who	completed cause of dea	Ittem 23a) (7		· (/) (, ,	200	20910
(o V		MARIA T. THYAC			REST GLE	N RD	Su	VER	SPRIMI	i M	
	Stat	е	31. Date filed (Month, Day, Year)	32. Redsh	s Signature	and the same of th		1	- y tur? ****	C> 1 1 4 1 1 0 0		
	Registra	ar I	SEP 10	2009 Leven		barker						

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or Print in Black Indelible Ink Ensure All Copies Are Legible.

aura Leah Hov		Ctate of many and a special		Rygiene14/0	9 Jh	19 2884
		Registrar	ate of Death	Reg 2. Date of Death	. No.	3. Time of Death
Physici ledical Exam		1. Decedent's Name (First, Middle,Last) Laura Leah Howerton			Day Year 2009	1313 hrs
		Facility Name (if not institution, give street and number) Oak Grove Drive #A	4b. City, Town, or Location of Dea Middle River	th	4c. County of Dea Baltimore Co	
Funeral		5. Social Security NumbelITIK 6. Sex 7. Age (In yrs. last birt	hday) If Under 1 Year If Under 24H	rs. 8. Date of Birth	(MM/DD/YYYY) 9. E	Birthplace (State on TK
Director		1 M 2XF 44	Yrs. Months Days Hours M	Dec 1,	1964	country)Germany
		Usual Residence of Decedent				10d. Inside City Limits
w any		10a. State 10b. County 10c. City, Town				1 Yes 2 No
faryland 28a-f show	į	MD Baltimore M 10e. Street and Number	iddle River	1100	g. Citizen of What Co	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho maite event, the Medical Examiner must be notified at once.	Director	63 Oak Grove Drive #A	21220		USA	
with the rise 23a	ral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Ongin? (If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Am White, etc.	erican Indian, Black,
death or iten	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No		to Ricari, etc.)		
after ral", o	by F	Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify: Decedent's Usual Occupation (Give kind of	fundi dono rea 1-		white s/Industry runk
hours	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use r	etired)	10b. Killa of Basilles	3/industry diffe
36 hin 72 e. than	Completed		Disabled		none	
5-00 ed with ygien other	Con	17. Father's Name (First, Middle, Last)	unk 18.Mother's Na	me (First, Middle, M	laiden Surname)	unk
21215-0036 Juld be filed within 72 Mental Hygiene. marked other than ' e event, the Medical	Be	William Howerton	Mar	-		
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after no I Health and Mental Hygiene. tt. If item 27 is marked other than "natural", other traumafic event, the Medical Examiner.	₽	19a. Informant's Name/Relationship (Type, Print) Mary Howerton/mother	1 Majling Address (Street and Number of 112 Perm Street Ba	or Rural Route Numb Baltimor	ber, City or Town St. Ce, MID 212 MD 21201	20 Code)
alt alt		U.C.M.E.	of Disposition (Name of cemetery,	Date	20c. Location - City	or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State crema	tory or other place)			
드리의 등등		Donation 5 X Other Specify: in state	22. Name and Address of Facility		D 1.1	0.1.
Balti permit. Departn Imports		21. Signature of Funeral Service Licensee Ronald S. Wade Director	22. Name and Address of Facility State Anatomy Boa Baltimore, MD 21		Baltimor	e Street
Physiciar		23a. Part Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line.	not enter the mode of dying, such as cardia	c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/ /Medica xamine		Immediate Cause (Final disease a Combined methac	done & citalpram in	toxicatio	n	Death
Adminie		or condition resulting in death) Due to (or as a consequence of):				1
	e e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause				
ted I Insit	Exa	events resulting in death) Last Due to (or as a consequence of):				
tox 68760, eath certificate be executed a stending physician and for use as the burial - transit	dical	X UNPENDED AMENDED 23a, 27, 28a-	-f,permE, g895 9/28	/09 TT		
'60, cate be physic	Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	· ·
Box 68760, s death certificate b the attending physical for use as the bur	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at time of death	Fetal death 3 Ectopic pre Other (Specify)	gnancy	Month	Day Year
Box e death the atter	ysic	1 Yes 2 No 9 V Unknown 9 Unknown	5 Other (Specify)			
C, da the		Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.			e to the cause of death?
s, P.C. irres that signed				_		Probably 4 Unknown
ords, w requir ts been s should!	Completed			24a. Was autop		e autopsy findings available to completion of cause of
Reco The law cate has	u o			1 Yes		Yes 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	26 Place of Death (Che			
Physic rthis	lo L	1 Yes 2 No Inpatient 2 ER/	Outpatient 3 DOA Outpatient 3 Nu Time of Injury 28c. Injury at Work?		Residence 6 O how injury occurred	ther: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death. After this certificate has been sided in by the fineral director nace 2 should be done.	i.	1 Natural (Month, Day, Year)	1 Ves 2 X No	unk		
IVISION or Attend after death. Director:	icat	2 Accident Investigation 28e. Place of Injury - At home,	farm, street, factory, office building, etc.	28f. Location (S	Street and Number o	r Rural Route Number, City
Divisior Bospital or Attend 4 hours after death Funeral Director:	Certification:	3 Suicide 6 X Could not be determined (Specify)		Middle S	River, MD	Grove Dr #A
Ilospital 24 hours Funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, d	eath occurred at the time, date and place,	and due to the caus	se(s) and manner as	stated.
To the Hos within 24 h To the Fur	Medical	one) 2 Medical Examiner:On the basis of examination and/or and manner stated.		ed at the time, date		
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed August 22, 20	
		Mongarite the Grill			710g03(ZZ, ZC	
		30. Name and address of person who completed cause of death (Item 23a Margarita Korell MD. Assistant Medical Examiner) 111 Penn Street, Baltimore, M	1D 21201		
	State	COAR- intents Simple			·	

Registrar

OCME

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** ROBERT August 30, 2009 6:00 AM M 4ac /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | 3701 International Drive Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑** M 2□ F New York 93 May 30, 1916 Director 577-40-3216 Usual Residence of Decedent filed within 72 hours after death with the Maryland I Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Marcol Event, incl. until be putified a once. 1 ☐ Yes 2√ No MDDirector Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 USA 3701 International Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: white Completed by 3 Widowed 4 Divorced 42-47 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 5+ city manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harris Hacken Yetta Hacken ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8508 Pineway Laurel, MD 20723 Hazel Hilliard/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of the neral 1 division of 1 d State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between one cause on each line Onset and Death Immediate Cause rind disease or condition resulting in death) 10 mars **Physician** 3 Chemy /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (ur as Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 2 No P.O. ed by the detached □Yes 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page performe 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 54 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 31918 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wind Boulevand, Siver bering Maryland 2 305 North 31. Date filed (Month, Day, egistrar's Signature Year) Registrar

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Records,	:: The law requires tha
Division of Vital F	o the Hospital or Attending Physician:
B	To the Hosp

			Please	Type or Prir								gible.	
	-	For State Registrar		State of Ma	aryland / I	•	rtment of F <i>tificate of</i> a		nd Men		giene Reg. No. 🥍	000	0001.2
		Registrar Decedent's Name	(First, Middle, L	ast)						ate of Dea	ath	Vanu	3. Time of Death
Physicia /Medic			HILDA	Α.	HOWARD					nonth ptembe	er 4,	2009	4: 30 a ^M
Examin			. •	ive street and number) 1th Care Cene	ter		4b. City, Town, o		Death			nty of Death	
Funeral		5. Social Security Nut 215–18–0951	mber 6.		e (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days		Min. (/	ate of Birt Month, Da	y, Year)	Cour	
Director		Usual Residence of D	Decedent						Aug	ust 3	3, 1923	Mary]	
aryland Show	_		10b. County	1.1	10c. City, Tow	vn or Loc						1	0d. Inside City Limits 1 ☐ Yes 2 No
the Ma	ecto	Maryland 10e, Street and Number	Anne Art	nuger			Pasadena 10f. Zip Code				10g. Citizen	of What Cour	
th with the Marylan 23a or 28a-f show uet be calified at	Funeral Director	525 Sylvies					211	122			-	S.A.	,
r dea	nue	11. Marital Status		12. Was Decedent Armed Forces? 1 □Yes 2 1	Ever in U.S.	13. W	Vas Decedent of H Yes, specify Cuba	Hispanic Origi an, Mexican, I	n? (Specify ` Puerto Ricar	Yes or No n, etc.)	- 14. F	Race - Americ Black, White,	
be filed within 72 hours after death with the Maryland tall Hygiene. Ad other than "natural", or items 23a or 28a-f show event, I'm Medical Eventions or ust be matted.	þ	1 ☐ Never Married 3 🕱 Widowed 4	_	1 ∐Yes 2 🔣 If Yes, Give Year or Dates:	No	1	□Yes 2ばNo	Specify:			Spe	_{ocify:} Whit	ce
"natur	Completed			Education rade co <i>mpleted)</i>	16a	. Deced	ent's Usual Occup kind of work done OO NOT use retired	pation during most o	of working		16b. Kind of	f Business/In	dustry
i withii jiene. r than	mo	Elementary/Second 12	dary (0-12)	College (1-4or 5	5+)		Homemaker	<i>5</i> ,			Own 1	Home	
tal Hyg	Be C	17. Father's Name (F						18. Mother's			Maiden Surr	name)	
ould by Men d Men narke natic	၉		Kroschin			h h h = 10°		Anı		hmidt		Otata Zia	Codel
nd 2 st aith an 27 is r r traur		Thomas M.		(Son)	1	,	g Address <i>(Street</i> ittle Cree						o Code)
jes 1 ai t of Hez if item or othe	Ì	20a. Method of Dispo		☐ Removal from State	20b. Place of cemete	of Dispos	sition (Name of latory or other place	ce)	Date	2000		on - City or To	
permit, Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "n any injury or other traumatic event, the Med once.		4 ☐ Donation 5	5 Other (Spec	ify)	Glen H	1	Mem. Park	1	pt, 9,		Glen Bu		aryland
Depa Impo any ii		- Jan	114	I Char	M	/ McC 320	Name and Addre 2111y—Polyr 24 Mountair	niak Fun n Road, 1	eral Ho Pasaden	me P.A a, Mar	yland 2	1122	
		23a. Part 1. Enter the shock, or heart	e disease, or cor t failure. List onl	mplications that caused y one cause on each li	the death. Do								Approximate Interval Between Onset and Death
Physician /Medical	4	disease or condition resulting in death)	Final	a	Car	elri	les	Mer	atory	w	rest		Second
Examiner				Due to (or as	a consequence	or):	turi	True	rum	Nus	'n		Zdan
ed sit	iner	Sequentially list condificant, leading to immoduse. Enter Underly Cause (Disease or in that initiated events	ditions, nediate lying	Due to (or as	a consequence	of):	20000	6.0	O. St	2	20		(col
e executed	Examiner	that initiated events resulting in death) La	ast	c. Due to (or as	a consequence	of):	71000	Die	1000	70	1	-	ZWam
cate be ohysicia the bur	dical			d			1.00	- Xiari	1 W	Mo	~		fean
certific	/Me	IF FEMALE: 23b. Was decedent p	pregnant	23c. If yes, outcome					,		23d.	Date of deliv	erv
e death the atte	Physician/Medica	in the past 12 m 1 ☐ Yes 2 🖸	nonths?	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnand Other <i>(specify)</i> _	су				Month	Day Year
that the ned by detach	F.		cant conditions	contributing to death b	ut not resulting	in the un	derlying cause giv	ven/in Part I.		23e. Did t	obacco use c	ontribute to t	he cause of death?
equires en sigr	ted by	Re	exent	Septie	Urth	M	20 / 1	hip		1 🗆 '	Yes 2 N	o 3 Pro	bably 4 Unknown
ie law n has be je 2 shi	Completed						V			24a. Was autor perfo	an 24 osy ormed?	b. Were auto prior to co death?	opsy findings available impletion of cause of
an: Th tificate or, paç		25. Was case referre	ed to medical					26 Place o	of Death (Ch	1 ☐ Yes	2 1 No	1 ☐ Yes	2 No
nysicia nis cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ ¶		Hospital: 1 Inpatio	ent 2 ER/O	utpatient	t 3 DOA Oth				dence 6	Other (Speci	fy)
ling Pt	ion:	27. Manner of Death 1 🖸 Natural	5 Pending	28a. Date of Inju (Month, Da	ury 28b.	Time of Injury	28c. Inju			Describe I	how injury oc	curred	
Attend death ctor: by the f	ficat	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not determine	be 28e. Place of Ini	ury - At home, f	arm, stre	M 1 C]Yes 2 □ No	28f. L	ocation (Street and Nu	ımber or Run	al Route Number,
tal or / rs after al Dire	Certification:	4 Homicide	determine	building, et	c. (Specify)				(City or To	wn, State)		
To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b.	Medical			Physician: To the best aminer: On the basis of and manner st	of examination a								
To th To th	Me	29b. Signature and ti	itle of certifier	em Her	sod o	ND	29c. Licens	se number	75		29d. Date sig	ened (Month,	Day, Year)
		30. Name and addres		o completed cause of c				nd 21601					
Sta	te	31. Date filed (Month			_			21001					
Registra		SEP 1	0 2009	Denew	ar's Signature	LARGE							
UMU 17 Day 1/20	01												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 SEPTEMBER 12:40 AM MALAMED HUCKSTEADT ESTHER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE RANDALL STOWN EASONS HOSPICE @ NORTHWEST HOSPITAL Date of Birth (Month, Day, Year) 11/29/1923 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days 1 □ M 2 🗶 F Months Hours 85 MD Director 220-14-1006 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It is Medical Experience must be rediffed at 1 □Yes 2X No Director MD **BALTIMORE** OWINGS MILLS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 WESTGATE COURT 21117 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. WHITE <u>ک</u> Specify: 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) and 2 should be filed within eath and Mental Hygiene.

m 27 is marked other than College (1-4or 5+) CLERICAL STATE OF MARYLAND 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JUL TUS MAL AMED BESSIE GOL D ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i HARRY RICHMAN / COUSIN 6 WESTGATE COURT, OWINGS MILLS, MD 21117 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20a. Method of Disposition Department of I Important; If its any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CARROLL CREMATION INC 09/08/2009 HAMPSTEAD, MD 4 Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 21. Signature of Juneral Service Lice 22. Name and Address of Facility Latt 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MULTS **Physician** disease or condition resulting in death) Lo Bar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the critical Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-transit Due to (or as a consequence of): nding physician a Box 68760, certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No atter 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an COMMO autopsy performed After this certificate 2 200 1 ☐Yes 2 ☐No 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{X} \) Other (Specify \(\text{HOSPICE} \) Hospital: 1 \square Inpatient 2 \square ER/Outpatient 3 \square DOA 1 ☐ Yes 2 💢 No မ 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Tyes 2 🗌 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 029085 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15 V

State Registrar

SEP 1 0 2009

J-

31. Date filed (Month; Bay; Year)-



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 23845

James Robert Ifenh		For State	Sta	ate of Maryla	nd / Depar <i>Cert</i>	rtment of tificate of	Health and Death	d Mental	Hygiene	201	39 2084			
Physician/	Re	egistrar Decedent's Name	(First, Middle	e,Last)					2 Date of Death		3. Time of Death			
Medical Examine	r			James Ro		Isenhar	t lb. City, Town, or	Location of D	Month September	3, 2009 4c. County of Deat	2100 hrs			
1 ,	4	a. Facility Name (if Outerloop of					Baltimore			Baltimore Co				
Funeral Director	5	. Social Security Nu.		6. Sex	7, Age (In yrs. Ia 70	st birthday) Yrs	Months Day	_		(MM/DD/YYYY) 9. Bi 24,1938 C	ign country) WVA			
	ι	Isual Residence of		I_AW ZI							10d. Inside City Limits			
ow any	1	0a. State 1	10b. County	1-	10c. City,	Town or Locat		York No	ew Salem		1 Yes 2 X No			
he Maryland o or 28a-f sh iffed at once	<u>.</u>	0e. Street and Num		rk		-	10f. Zip Code		10	g. Citizen of What Co	untry?			
with the Maryland ns 23a or 28a-f show he notified at once.		1112 A	Slage1				1736		O / Cassify Voc or No.	United S	States erican Indian, Black,			
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene in the matural", or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transmite event, the Medical Examiner must be notified at once The December of the property of the property of the content of the property of	ומ	Marital Status Never Marrie	ed 2 M	arried Armed Fo		S. 13. Wa	as Decedent of Hi 'es, specify Cuba	n, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	White, etc.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
ufter der Il", or i	2 2 -	3 X Widowed	4 Div	1 X Yes vorced If Yes, Give Yea or Dates:	² No 1956–5	9 1 🗆	Yes 2 X No		t f day	Specify: 16b. Kind of Busines	White			
hours a		15. Decedent's Ed		cify only highest grad		16a. Deceder during n	nt's Usual Occupa nost of working life	ation (Give kin e. DO NOT us	se retired)	Crown Co				
hin 72 thin 72 te. than "	Сошріете	12 Years	indary (0-12)	College (1	40.017	Mil	<u>lwright</u>			Seal_Co				
5-0036 iled within 72 Hygiene. I other than the Medical		17. Father's Name (Name (First, Middle, N					
2121 Suld be fi Mental marked c event,	8 -	Henry 19a. Informant's Na	Clay me/Relations	Isenhart_ ship (Type, Print)		19b. Mailir	g Address (Stre	eet and Numbe	usan Cutli er or Rural Route Num	ber, City or Town, St	ate, Zip Code)			
MD 3	_	Melissa	A. Ni	.ckel (Dau	ghter)	300	Pinewoo	od Road	d <u>Dunda1k</u>	Maryland	21222 or Town, State			
or Heal of Heal	١	20a. Method of Disp 1 X Burial 2		n 3 Removal fi	om State	crematory or o	ther place)							
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	-	4 Donation 5 21. Signature of Fu	Other S	pecify: Licensee				of Franklike	9/9/2009 ral Home of	Baltimo				
Ba perm Depa Imp							7922 Wis	e Ave.	Dundalk, rdiac or respiratory arr	Maryland	2122 Approximate Interval			
Physician /Medical		23a. Part I. Enter th failure. List on	ne disease, only one cause	e on each line.			the mode of dyin diovascular D		diac of respiratory and	sor, orroad, or treest	Between Onset and Death			
aminer		Immediate Cause (or condition resulti			a consequence of		JIOVA SCOTAL D	Jocaso						
	اير	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):												
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Box 6876(e death certificate the attending phy ed for use as the b	Physician/M	1 Yes 2		-1	nant at time of one	death 5	Other (Specify)							
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ires that th	ed by	COPD, Dia	abetes, h	ypertension,					1 ✔ Ye	an I 24b. Wer	re autopsy findings available			
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cal Rec		25. Was case refe	arred to medi	cal			26.PI	ace of Death ((Check only one)	2 No 1	165 2 116			
Vital hysician this cert	o Be	examiner?	2 No	Hospital: 1	Inpatient 2	ER/Outpatie		Other ₄	Nursing Home 5	Residence 6				
ing Ph After t	Ju: T	27. Manner of Dea			te of Injury hth, Day,Year)	28b. Time	. , ,	Injury at Work		how injury occurred				
Division tal or Attendi ar after death.	Certification: To	2 Accident 3 Suicide	6 C	ould not be	ace of Injury - At	home, farm, s	treet, factory, office				or Rural Route Number, City			
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b		4 Homicide 29a. Certifier (Check only		Physician: To the b		edge, death oc	curred at the time	e, date and pla	ace, and due to the ca	use(s) and manner as	s stated.			
To the Hos within 24 h vo the Fun completely	Medical			and marine	is of examination	and/or invest		ense number	ccurred at the time, dat	29d. Date signed	(Month, Day, Year)			
	Σ	29b. Signature an	25	attens	Veel	4086		.C.M.E.		September 4	i, 2009 			
		30. Name and add		on who completed co	ause of death (It Medical Exan	em 23a) niner 11	1 Penn Stree	t, Baltimor	e, MD 21201					
St	ate				Registrar's Sign	ature								
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			For State Registrar	State of Ma	aryiario /		rtificate of L			Reg. No.	0.9	28845
			Decedent's Name (First, Middle, Last	it)					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic			BLANCHE	JANSSO	N			AUG 2	8 2009		11:05 P ^M
-	Examin	er	4a. Facility Name (If not institution, give					Location of Death		4c. County	of Death	
100			NATIONAL NAVAL 5. Social Security Number 6. S		ENTER e (In yrs. last	hirthday)	BE'	THESDA If Under 24 Hrs.	8. Date of Birtl		ONTGO	DMERY blace (State or Foreign
	Funeral Director				63	Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day Aug. 23	, 1946	Coun Engl	itry)
	land ow		10a. State 10b. County		10c. City, To	own or Loc	eation				1	0d. Inside City Limits
	Mary a-f sh	tor	Virginia Fairfax	ς	Alex	andri	a					1 □Yes 2 😿 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	itry?
	ath wi		6308 Willowood Lar				22310-			USA		
00	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is after Example in must be mailfied anone.	by Funeral	11. Marital Status 1 ☐ Never Married 2 🖾 Married	12. Was Decedent E Armed Forces? 1 ∐Yes 2 ☑ N If Yes, Give			Vas Decedent of Hi fYes, specify Cuba □Yes 2⊠No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bla Specif	ce - Americ ick, White, e	etc.
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2	Ald be Aental rked o	To B	John Walter Robert	s				Hilda	Constan	ce Oakl	.ey	
ary	shou and N		19a. Informant's Name/Relationship (Type. Print)	1	19b. Mailin	g Address (Street	and Number or Rui	al Route Numbe	er, City or Town	, State, Zip	Code)
, E	and 2 lealth m 27 i		Neil R. Jansson, H	lusband		6308	Willowood	d Lane, A				22310-2919
Daltilliore	Pages 1 nent of H ant: If ite ury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Funei of C	e of Dispos etery crem ral C hanti	sition (Name of patory or other place hoices 11y	^{e)} Septe	mber 2	20c. Location Chanti		Virginia
ספור	permit. Departi Imports any inj	s la	21. Signate of Funeral ervice Licen	#CC ary Roles	CO508 Downer		Name and Address 4522L Lee	ss of Facility Fun	eral Ch	oices o	f Cha	ntilly
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	/Medical		resulting in death)	Due to (or as								
	Examiner	<u>_</u>	Sequentially list conditions,	b								
	nsit	nine	Sequentially list conditions, in the limit of cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseguen	ce on:						
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00	ertifica ing ph e as th		IF FEMALE:						-			
ב ב	attending for use a	sician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal de	ath 3	Ectopic pregnancy Other (specify)	у		1	ate of delive Ionth	ery Day Year
5	y the check	nysic	1 □ Yes 2 XNo 9 □ Unknown	9 Unknown	time or deat	JI 5 L						
7	s that ned b deta	by Phys	Part II. Other significant conditions of	ontributing to death bu	ut not resultin	g in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use cor	tribute to th	he cause of death?
ž	quires	ed b							1 □ Y	es 2 🗓 No	3☐ Prob	bably 4 Unknown
necolus,	Attending Physician: The law requires that the disclassing death. rector: After this certificate has been signed by the by the funeral director, page 2 should be detached	Completed								rmed?	prior to co death?	opsy findings available impletion of cause of
<u> </u>	an: T	o .	25. Was case referred to medical					26. Place of Deat		212 No ne)	1 □ Yes	2 LINo
>	nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 X Inpatie	ent 2 ER	/Outpatien	t 3 DOA Othe	er: 4 🗌 Nursing Ho	ome 5 Resid	dence 6 □Ot	her (Specil	fy)
) = 5	iding Pl th. : After the funeral		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Day	ry 28 y, Year)	b. Time of Injury	Work	yat ⟨? Yes 2 ∐No	28d. Describe h	now injury occu	rred	
	To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	Certification:	3 Suicide 6 Could not be determined		ury - At home c. <i>(Sp</i> ec <i>ify)</i>	, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Num vn, State)	ber or Rura	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	Medical C		nysician: To the best on the basis of and manner sta	f examination							
	To the within To the comple	Me	29b. Signature and title of certifier	. 1	,		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
h			Lores &	7 Con	to.	M. C	0101	236858 (\	7A)	08/	31/	09
			30. Name and address of person who	completed cause of d		Ba) (Type, I	211	NATIONAL		EDICAL	CENTE	ER
			CORY A. CARTER	LCDR MC	USN	100		BETHESDA				
	Sta Registra		31. Date filed (Month, Day, Year)	4	ar's Signature	be	getted					

	 State Registrar 					rtment of I tificate of				Reg. No.	00011	9 288
n	1. Decedent's Nan	ne (First, Middle	Hazel	D. Joi	nes		_		2. Date of De Month	eath Day	2009	3. Time of 8:45
i r	4a. Facility Name	'If not institution	n, give street and number	er)		4b. City, Town, o	or Location o	f Death			County of De	
	1920 E	. Lafa	ayette A	venue		Balto					N/A	
	5. Social Security I		6. Sex 7. 1 □ M 2√2 F	Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, D	av, Year)	9. Bi	irthplace (State or Country) MD
ŀ	212-12- Usual Residence of		_ A	101	113.				7-15	-190	18	FID
	10a. State	10b. County		10c. City, To	own or Loc	ation						10d. Inside Cit
Director	MD		N/A	Balt	imor	·e						1 DMVes
5	10e. Street and Nu					10f. Zip Code					izen of What C	Country?
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runeral	 Marital Status Never Mar 	ried 2 Marr	12. Was Decede Armed Force ried 1 ☐ Yes 2	nt Ever in U.S. is? ►1 No	13. V	Vas Decedent of I Yes, specify Cub	an, Mexican	gin? (Spe , Puerto	Rican, etc.)	o-	14. Race - Am Black, Whi	
<u>~</u>	3X Widowed	_	If Yes, Give		1	□Yes 2MNo	Specify:				Specify:	Black
completed	/Cons	15. Decedent	t's Education	1	6a. Deced	ent's Usual Occup	pation	of marki		16b. Ki	ind of Busines	
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מ	17. Father's Name		ield Dock	0.817					(First, Middle havis	e, Maiden	Surname)	
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	Evelyn			'		Chape!					er Sp	
-	20a. Method of Dis			20b. Place	e of Dispos	ition (Name of	- 1		ate		ocation - City o	
		☐ Cremation 5 ☐ Other (S)	3 ☐ Removal from Sta	ite	-	atory or other pla	i	7.7	2000	7	- 7	a.1 a.
ŀ	21. Signature of F			ME		ary Cer	ess of Facility		<u>-2009</u> arch			del Co,
	1an	m Min				1101 E	. Nor					MD 2120
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
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Physician /Medical

Examiner

Funeral Director

To Be Completed by Funeral Director

Please Type or Print				-	_	
1 _ State		artment of He rtificate of De		lental Hygie Reg.	0000	0001.8
Registrar 1. Decedent's Name (First, Middle, Last)		timoato or b		2. Date of Death	140.	3. Time of Death
Dorothy Vi	vian Jame	C		Month	Day Year	M I
4a. Facility Name (If not institution, give street and number)	vian Jame	4b. City, Town, or Lo		September	7, 2009 4c. County of Dea	12:15 A. ^W
Tate Hospice House			hicum		Anne A	rundo1
	In yrs. last birthday)	If Under 1 Year	f Under 24 Hrs.	8. Date of Birth	9. Bi	rthplace (State or Foreign
214 26 1529 ¹□M 2\sqrt{1} 7	7 Yrs.	Months Days	Hours Min.	(Month, Day, You 03/02/1		aryland
Usual Residence of Decedent						
	0c. City, Town or Lo					10d. Inside City Limits
Maryland Anne Arundel	Baltim	ore				1 □Yes 2 X No
10e. Street and Number		10f. Zip Code		10g	. Citizen of What C	Country?
208 W. 12th Avenue		21:	225		U.S.A.	
11. Marital Status 12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Sp. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 X No	Specify:		Specify: T	The details of
3 🖫 Widowed 4 ☐ Divorced Year or Dates:						White
15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupati kind of work done dur DO NOT use retired)	on ring most of work	ing 16	b. Kind of Business	s/industry
Elementary/Secondary (0-12) College (1-4or 5+)	1	nemaker			Own I	Home
8th 17. Father's Name (First, Middle, Last)	1101		8 Mother's Name	e (First, Middle, Ma		Tome -
John Larki	0410	''		istina Sc		
19a. Informant's Name/Relationship (Type. Print)		ng Address (Street and			-	
Darlene Erbe / Daughter 20a. Method of Disposition		- 5th Aven		Baltimore	c. Location - City o	
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cre	osition (Name of matory or other place)			,	
4 □ Donation 5 □ Other (Specify)		en Mem. Par		1/2009 6	len Burn	ie, Maryland
21. Signature of Funeral Service Licensee		2. Name and Address	GU	nce Funer		
Homa granus						ryland 21225
23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do not en	ter the mode of dying,	such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition	740	of Cano	Pr			Oliset and Death
resulting in death) Due to (or as a continuous and	consequence of):					
Sequentially list conditions						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):					
that initiated events						
resulting in death) Last Due to (or as a	consequence of):					
d						
IF FEMALE:						
23b. Was decedent pregnant 23c. If yes, outcome pr		☐Ectopic pregnancy			23d. Date of d	
In the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant at till		Other (specify)			Month	Day Year
9 Unknown)						
Part II. Other significant conditions contributing to death but	not resulting in the u	ınderlying cause given	in Part I.	23e. Did toba		to the cause of death?
				1 Yes	2 No 3 I	Probably 4 ☐Unknown
				24a. Was an	24b. Were	autopsy findings available
				autopsy performe	d? death?	
25. Was case referred to medical			26. Place of Deat	th (Check only one)	1 L Y e	OSZZE HOUSE
examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient	2 ER/Outpatie	Other		ome 5 Resident	ce 6 Other (Sp	
27. Manner of Death 28a. Date of Injury	28b. Time o			28d. Describe how		
D⊟Natural 5 Pending (Month, Day) 2 Accident investigation	Year) Injury		es 2 No			
C Could not be	/ - At home, farm, st (Specify)	reet factory office		28f. Location (Stree	et and Number or I	Rural Route Number.

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

> 25. 27 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
>
> 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

(30) and address of person who completed cause of death ype, Print) 4

31. Date State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 0757 09 Vayne 66 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04–12–1950 Funeral 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Days Min. 1 M 2 □ F Director 214-56-1598 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f show the Wedcal Examinating by notified at Director 1 ☐ Yes 🏋 ☐ No Glen Burnie MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with I and to Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or i any or other traumatic event, I'm Medical Exprising 1 and 1 and 10 or other traumatic event, I'm Medical Exprising 1 and 1 and 10 or other traumatic event, I'm Medical Exprising 1 and 1 and 10 or other traumatic event, I'm Medical Exprising 1 and 10 or other traumatic event, I'm Medical Exprising 1 and 10 or other traumatic event, I'm Medical Exprising 1 and 10 or other traumatic event, I'm Medical Exprising 1 and 10 or other traumatic event, I'm Medical Exprising 1 and 10 or other traumatic event, I'm Medical Exprising 1 and 10 or other traumatic event. 21061 1008 Sundown Road U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 MYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🗓 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heating & Cooling Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude Kirby Krauch William မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 1008 Sundown Road Mrs. Cheryl M. Krauch / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09-12-2009 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Multo organ /Medical Due to (or as a sequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-transi Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ⋛ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed: 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∭XYes 2∐No 1 Dinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 X Natural After t 28h. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 2 ☐ Accident 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of de th (Item 23a) (Type, Print) Someth

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10h- of Maryland / Department of 22-dath and Mental Hygiene

		1 _ State	state of Maryland		Herle Ur 44 Ficate of L			iene _{ag. No} 2 () ()	9 2	28850
	•	Registrar 1. Decedent's Name (First, Middle, Last)		00/11/	routo or i	Journ	2. Date of Deal		3.	. Time of Death
	sician		11				Month A11011ST	10, 2009	rear 6	6:00 AMM
	dical	Charles Francis Kt 4a. Facility Name (If not institution, give stri		4	b. City, Town, or	Location of Dea		4c. County of		7.00
EXAI	niner	Hillside House As			Clarks			Но	ward	
Funer	al	5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	Under 1 Year	If Under 24 Hr		Vear) S	9. Birthplace Country)	(State or Foreign
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P.		Usual Residence of Decedent	100 000	T					104 1	Inside City Limits
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Me M	Director							0g. Citizen of Wh		
with t	늅	JJUZ Harris Farm I	oreland Drive		10f. Zip Code 210	29 2106		USA		
seth y	Funerai	11 Marital Status	. Was Decedent Ever in U.S	13 Wa			Specify Yes or No-		- American Ir	ndian.
ter de	ij	11. Marital Status 12 1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 📉 No	If Y	es, specify Cuba	n, Mexican, Pue	nto Rican, etc.)	Black,	White, etc.	,
irs af	þ		If Yes, Give Year or Dates:	1 🗆	Yes 2∏ No	Specify:		Specify:	white	
2 hou	led be	15. Decedent's Educa	tion		t's Usual Occup			16b. Kind of Busi	iness/Industr	ry
hin 7.	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retired	during most of w d)	orking			
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uld b Menti	10	John Charles Arno	ld Knell			Caroli	ne Estell	a Greifz	:u	
2 sho and and is my		19a. Informant's Name/Relationship (Type					Rural Route Number	r, City or Town, Si	tate, Zip Cod	de)
end in 27		Diane M. Ahlquist/				Lane L	aurel, MD	20707		
t ten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer		ace of Dispositi metery, cremat	on (Name of ory or other plac	(e)	Date	20c. Location - C	ity or Town,	State
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Dhysisis		23a. Part Letter the disease, or complica shock, or heart failure. List only one Immediate Cayse (Final disease or condition	cause on each line.	AL 1.	VFARCT	70N			Qn	erval Between eset and Death 2 2 1 25
Physicia /Medic		disease or condition resulting in death)	Due to (or as a conseque						/-	
Examin	er		200 10 (0) 43 2 00.13044.	31,00 31).						
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Ing P	<u></u>	27. Manner of Death 1 ⊟Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe h	ow injury occurre	a	-111113
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or Attending Physician: ther deeth. Director: After this certifica in by the funeral director, f	Certification:	4 Homicide determined	28e. Place of fnjury - At hor building, etc. (Specify,	ne, larm, stree	t, factory, office		City or Tow	n, State)	r or Hurai Ho	oute rvurnber,
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To the Hospital or Attending Physician: The law within 24 hours after deeth. To the Funaral Director: After this certificate hes completely filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying Physic (Check only 2 Medical Exemina one)	cian: To the best of my know ir: On the basis of examinati and manner stated.							
o the ithin i	Me	29b. Signature and title of certifier	and market states.		29c. Licens	se number		29d. Date signed	(Month, Day	/, Year)
F ≥ F 8		1	- wil		200	64911		08	1201	12009
		30. Name and address of person who com	pleted cause of death (Item	23a) (Type Pr						12009
			VILLIAM DI	-	CAT	21) NIC	CE M	0- 2	1228	
	State	31. Date liled (Month, Day, Year)	62. Registrar's Signat	ure	1					
Reg	istrar	SEP 1 0 2009	32. Registrar's Signat	gara						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 8, 2009 **Physician** 4:45 P Killen Lovely Helena /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Marley Neck Health & Rehab. Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 □ M 2 X F Months Days Hours 006-18-4609 97 July 7,1912 Director Maine Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City. Town or Location 10a State 10d Inside City Limits "natural", or items 23a or 28a-f show sdical Exa⊡iner must be notified at 1 ☐ Yes 2 ☐ No Director Anne Arundel Marvland Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 258 Ullman Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: White þ 3 N Widowed 4 □ Divorced Completed other than "natu vent, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 N/A Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Henry Lovely ည Annie Collins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye H. Graham (Niece) 258 Ullman Road Pasadena Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 09/10/09 Baltimore, Maryland 22 Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Fugeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** aldiac stoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 9☐Unknown signed by the and be detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy perform certificate 1□ Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 2 ER/Outpatient 3 DOA P 1 🔲 Inpatient After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours To the Funeral

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

3altimore, Maryland 21215-0036

State Registrar

Medical

29a, Certifier

(Check only one)

Adlitya

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) SEP 10 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chopra M

-D 600 Ridgel

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D57028

29d. Date signed (Month, Day, Year) 9-9-09

Avenue #231 Annapolis MD 21401

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Marie Lomax	

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	Ctate of Mondond / Department of Health and Menial H	voier
	State of Maryland / Department of Health and Mental H	, 9.0.

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Physiciar		gistrar Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
ledical Examin	"	Marie Inmax		Month Day September 6,		1403 hrs
	4	it admity ramo (in not motivation, g	. City, Town, or Location of Death Baltimore		4c. County of Death	N/14
Funeral Director	l	unknown 1 m 2 f 62 yrs.	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	8. Date of Birth (M		hplace (State or Foreign untry) VHR Carolina
ow any	_	sual Residence of Decedent Da. State 10b. County 10c. City, Town or Location	Itimula			10d. Inside City Limits 1 Yes 2 No
Maryland or 28a-f show	Director	De. Street and Number	10f. Zip Code	10g. (Citizen of What Cou	ntry?
	باع	Never Married 2 Married Armed Forces?	Decedent of Hispanic Origin? (Sp s, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
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5-0036 led within 72 hour tygiene. other than "natt	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	st of working life. DO NOT use retirements	red)	Dom	estic
F of Hyge	Be Com	7. Father's Name (First, Middle, Last) Workester	18.Mother's Name	(First, Middle, Maid	Jilliam	
MD 2121 d 2 should be fi lth and Mental n 27 is marked aumatic event,		9a. Informant's Name/Relationship (Type, Print) 19b. Mailing 25chell Williams-daugher 1929	Address (Street and Number or F Debutante I	Dr., Jock	Sonville	T-L 32246
of Heal		1 Burial 2 Cremation 3 Removal from State crematory or other	tion (Name of cemetery, er place) Cremator 9	Date 2	Oc. Location - City of Baltin	Tion
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caminer		Immediate Cause (Final disease or condition resulting in death) a. NATCOTIC INTOXICATION Due to (or as a consequence of): b.				
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit		3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fer 4 Pregnant at time of death 5 Ott	tal death 3 Ectopic pregn	ancy	Month	Day Year
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the star death. **I Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach.	Completed b			24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
eco The fav ate has	mo du			perform 1 Yes 2		Yes 2 No
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i of Vital Records ing Physician: The law requi After this certificate has been tuneral director, page 2 should	리	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 27 Manner of Death 28a Date of Injury 28b Time of			esidence 6 Ot	ner:
ion of tending F leath. tor: After		1 Natural 5 Pending Fd 9/6/09 Fd 1330	0 hrs 1 Yes 2 X No	unk		Rural Route Number City
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Division of Vital Records, To the Hospital or Attending Physician: The law requivitin 24 hours after death. To the Funeral Director: After this certificate has been a completely filled in by the funeral director, page 2 should	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occur one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ation, in my opinion, death occurred	ad due to the cause d at the time, date a	(s) and manner as s nd place, and due to 29d. Date signed (the cause(s)
	Σ	29b. Signature and title of certifier (A CM) (A)	29c. License number O.C.M.E.		September 7,	
10			nn Street, Baltimore, MD 2	21201		
S Regis	ate trar	31. Date filed (Month Sep Year) 2009 32. Registrar's Signature	bares			
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State of Maryland / Department of Health and Mental Hygiene 28853 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0115 A M Medical Eacility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Bastimore Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min 9-8-2009 Director unk infant Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MDCarroll Westminster 1 X Yes 2 No 10f. Zip Code **21157** 10g. Citizen of What Country? 10e. Street and Number Funeral 162 Liberty St. death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Completed by 1X Never Married 2 ☐ Married permit. Page 1 and 2 should be filed within 72 hours after 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) infant infant Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Wayne Winslow Luby Amy Jo Click f Health and № 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Jo Click-mother 162 Liberty St., Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Mem. 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State 9-14-2009| Finksburg, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fletcher Funeral Home Z 254 Ε. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a c) sequence of) or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an After this certificate has autopsy prior to completion of cause of death?
1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury 1 🗆 Yes 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 📆 Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur cause of death (Item 28a) (Type, Print) Avenue, Baltimore uis 212 31. Date filed (Month, Day, Year) State APR 1 4 2010 Registrar

Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death

	Physici /Medi		Mary C. Lusby		sept 8	Day 2009 Year 7:00 P M		
-	Examir		4a. Facility Name (If not institution, give street and number) Westminster Ridge	4b. City, Town, or Location of Death Westminste	4c. County of Death Westminster Carroll			
I	Funeral Director		5. Social Security Number 216-05-1175 6. Sex 1 Age (In yrs. last birthde	ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month Day Ye 9 - 15 - 19	9. Birthplace (State or Foreign Country) Maryland		
	Maryland	tor	Usual Residence of Decedent 10a. State	Location Westminster		10d. Inside City Limits 1 □Yes 2 □ No		
	with the	Il Direc	10e. Street and Number 507 High Acre Dr.	10f. Zip Code 21157	10g.	Citizen of What Country?		
36	s after death ", or items 2	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. 13. Armed Forces? 1 □ Yes 2 □ No 15 Yes, Give X	3. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked event, the "calletter in the periodic of the	Completed I	15. Decedent's Education 16a, De-	cedent's Usual Occupation ive kind of work done during most of working b. DO NOT use retired)	ng 16k). Kind of Business/Industry		
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	" = n =	S Y	John N. Cicone-son 100	ailing Address <i>(Street and Number or Rura</i> D5 Seamount Rd。 I				
saltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	rematory or other place)		altimore, MD		
Ball	Departition Depart), q	21. Signature of Funeral Service Licensee Floothur Themas O Flothur The	22. Name and Address of Facility Fle 254 E. Main St.	etcher E Westmir	Funeral Home		
	Physician /Medical	9999	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Severe Aortic Due to (or as a consequence of):	enter the mode of dying, such as cardiac or				
		dical Examiner	Sequentially list conditions, if any, leading to finite distribute ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Coronary Arte Due to (or as a consequence of): c. Due to (or as a consequence of):	ery Disease				
•	p = = = =	nysician/Medical		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Ye ar		
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מו הפכנ	within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Completed	Atrial Fibrillation		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 \sum Yes 2 \sum No		
1 V IL	is certification	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☒ No Hospital: 1 □ Inpatient 2 □ ER/Outpati	26. Place of Death ient 3 □ DOA Other: 4 □ Nursing Hom		a 6 ≱Other (Specify) Assisted		
SIOII OI	ath. or: After the he funeral	ation:	27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation 28a. Date of Injury (Month, Day, Year)	of 28c. Injury at 28	8d. Describe how in			
	rs after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	8f. Location (Street City or Town, St	and Number or Rural Route Number, ate)		
ho Hoeni	in 24 hou he Funer pletely fil	Medical	29a. Certifier (Check only one) 1 ★Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the caused at the time, date	e(s) and manner as stated. and place, and due to the cause(s)		
Ę	With Com	Σ	29b. Signature and title of certifier	29c. Lícense number D0050763		Date signed (Month, Day, Year) 9 – 2 0 0 9		
	ウレ		30. Name and address of person who completed cause of death (Item 23a) (Type Ernesto Mendoza 826 Washin		ator "	D 21157		
ı	Stat Registra		31. Date filed (Month, Day, Year) SEP 10 2009 32. Registrar's Signature	gton Rd. Westmin	ister, M	υ 2115/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year John T LaShomb 2009 09 11:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 16 Harding Road Glen Burnie If Under 1 Year | If Under 24 Hrs. Anne Arundel 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1**X** M 2 □ F Months Days Director 127-50-9544 8/8/1958 51 New York Usual Residence of Decedent 10a. State 10b. County show 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 ☐ No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 Harding Road 21061 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1XXYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electriction Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ LaShomb Eileen Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum Mrs. Maureen Gebbia / Sistor 7972 Cross Creek Drive Glen Burnie, MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/9/2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Atlantic Crematory Signature // uneral Serv 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD M01220 23a. Fart 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical as I attending p for use as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 50(2602 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐Yes 2 ☐No 2 Accident atter death Director; d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours att e Funeral Di etely filled ir

P.O. Box 68760 Division of Vital Records,

within 2

State Registrar

completely

1408 rain

29a. Certifier

(Check only one)

29b. Signature and title of certification

wer

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and due to the c

29c, License number

29d. Date signed (Month, Day, Year)

263726 mp MAJERODUNMI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** lanya 4:13 AM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAL HOSPITAL OF BALTIMORECITY BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 6. Sex -7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 215-02-9696 1 □ M 2 🖼 1 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 ☐ No Funeral Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes. specify Cuban_Mexican. Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Tes 2 Tho If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☐ NO ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dispatcher 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19a. Informant's Name/Relationship (pe. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Battimor 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 3512 Frederick Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Brai Anoxic disease or condition resulting in death) dey /Medical Due to (or as a consequence of): poxemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine MUCOUS Due to (or as a consequence of Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 → No 24a. Was an autopsy performed? Yes 2 \(\text{No} 1 Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Chec only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) runpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of De h 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

The law requires that the death certificate be executed of Vital Records, P.O. Box 68760, or Attending Physician: Hospital Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminar must be redified at

Health and Mental Hygiene.

Important: If Item 27 any Injury or other tr

Examiner

ng physician and as the burial-transit

nse

signed by the a d be detached fo

After this certificate has been

page 2 s

director,

funeral

filled in by the

Medical

(Check only one)

29b. Signature and title of certifier

Pages 1 and 2 should be

Maryland 2121

Baltimore,

within 24 hours after death. To the Funeral Director: A completely

the

State Registrar

KUBIN MAIZTIN MI 31. Date filed (Month

29c. License number

12 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) August 29, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

SINAI HOSPITAL OF BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vear **Physician** September 08,2009 HELENE MODLER 1:15A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph's Nursing Home Catonsville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 02/28/1915 1 □ M 2 1 F 94 Illinois 325-44-5501 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if tem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4 Rumford Drive #204 21228 United States by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Witek Mary Bryk ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Modler - Son 4 Rumford Drive #4 Catonsville, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Calvary Cemetery 09/14/2009 Sterling, Illinois 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Dayid J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Baltimore, Maryland 21229 21. Signature of Funeral Service bicensee Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carple Vaccular Atheen scleration years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, that y leading to include a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 ☐Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 200 No Jo Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours after use.... To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

Jyotin

31. Date filed (Month, Day, Year)

SEP 10 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Parikh

Medical

821 N. Ewaw St. ste 407

150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D32158

29d. Date signed (Month, Day, Year)

Baltimore, Mis

			State of Maryland / Department / Department / Departm	artment of Health and N rtificate of Death	nental Hygien/ Reg. N	CARC CRACA
			1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	Physicia		Owen McDaniel		8 14	
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
	Examin	er	901 Woodburn Ave.	Baltimore		
***	Francis		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Funeral Director		230-23-1307 X□M 2□F 83 Yrs.	Months Days Hours Min.	9/23/192	26 UNK
			Usual Residence of Decedent		37237.32	
	land		10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	Mary f sh	힏	MD Baltimo	re		tX Yes 2 □ No
	the Maryland r 28a-f show	Director	10e, Street and Number	10f, Zip Code	10g. (Citizen of What Country?
	with a or	0	901 Woodburn Ave.	21212	US	SA
	eath	Funeral	T40 W B - 1 1 5 - 1 1 1 0	Was Decedent of Hispanic Orlgin? (S)	pecify Yes or No-	14. Race - American Indian,
	er de	اج	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
5	rs aff	by	If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 □Yes XXNo <i>Specify</i> :		Specify:White
⋛	hour tural			dent's Usual Occupation	16b.	Kind of Business/Industry
က်	"ina	Completed	(Specify only highest grade completed) (Give	kind of work done during most of work DO NOT use retired)	-	TN T T Z
7	withii ene. than	m.	Elementary/Secondary (0-12) College (1-4or 5+)	NK		JNK
N	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f show event, I've fladical Evancials must be actified at		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	en Sumame)
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⋚	should be and Menta s marked umatic ev	မ	UNK	ng Address (Street and Number or Ru	rol Bauta Numbar Cit	v or Town State Zin Code)
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	es 1 and 2 should b of Health and Ment item 27 is markec r other traumatic e					Location - City or Town, State
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Ξ			4□Donation 5□Other (Specify) Atlanti	e crematory		21061 _
Baltimore,	permit. Departr Imports any inju			2. Name and Address of Facility Skarda Funeral	Lomo	9 Hudsin St.
מ	89 = 89		Promise L. Draide-n			timore,21224
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
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	/Medical		resulting in death) Due to (or as a consequence of):	400		
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	100	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
6"	uted d ansit	Ē	Cause (Disease or injury that initiated events			
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9	ifical g phy as th	edi				
Вох	eath certific attending p for use as	M	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery
m	leath atte	cia	in the past 12 months? 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
o	y the c	Physician/Me	9 Unknown			
σ.	v requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
Records,	uires sigr d be	d by			1 ☐ Yes	2 No 3 Probably 4 Onknown
Ö	beer shoul	Completed			24a. Was an	24b. Were autopsy findings available
ě	e lav has je 2 s	ld m			autopsy performed	prior to completion of cause of
<u></u>	r; Th icate i, pag				1 □ Yes 2 □	
Vita	ician Sertif ector	Be	25. Was case referred to medical examiner? Hospital:	Other:	ath (Check only one)	11 -
-	Physician; The la r this certificate had ral director, page 2	ုင	1 Inpatient 2 EH/Outpatie	ent 3 DOA 4 Nursing F	lome 5 Residence	
Division of	ing F	on:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day, Year) Injury	Work?	28d. Describe how it	njury occurred
S	tend eath or: /	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury At home farm of	M 1 □Yes 2 □No	206 1	(All when an Board Board Months
Ξ	al or Attending P s after death. I Director: After t d in by the funera	Certification: To	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	City or Town, S.	t and Number or Rural Route Number, tate)
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	Hosp 4 hou Fune Tely f	ical	29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i	ith occurred at the time, date and place nvestigation, in my opinion, death occi	e, and due to the caus urred at the time, date	and place, and due to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) and manner stated.	29c. License number	204	Date signed (Month, Day, Year)
	5 wit 2		29b. Signature and title of certifier	250, License number	290.	V1/1/2 -2
			world J. Joll	LUS8217		0/14/2009
	/		30. Name and address of person who completed cause of death (Item 23a) (Type	Print	7	n- Mx 10-1
	,		MARCEL 1. HOROWIZ 828	CUIHWX, S	ALTTHOR	E, IID ZIZO
	Sta		31. Date filed (Month Day, Year) 32. Resistrar Signature	La sel		

	•	State of Maryland / Department of Health and Mental Hy 1 - State Registrar Certificate of Death	Reg. No. 009 28859																			
Physicia /Medica Examine	al -	1. Decedent's Name (First, Middle, Last) Lorraine B. Moroney 4a. Fecility Name (If not institution, give street and number) 2. Date of D. Month Septe	Death Day Year 3. Time of Death 2mber 5,2009 10:17 A M 4c. County of Death																			
Funeral Director	ı	0/2 20 000	Frederick Sirth Day, Year) 27, 1926 Michigan																			
the Maryland r28e-f show notified at	To Be Completed by Funeral Director	Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Virginia Fairfax Oakton 10e. Street and Number 10f. Zip Code	10d. Inside City Limits 1 ☐ Yes 2 🕱 No 10g. Citizen of What Country?																		
033 cms &												2558 Yonder Hills Way 11. Marital Status 1	USA 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry									
Maryland 212 nd 2 should be filed with the and Mental Hygiene. 27 Is marked other ther treumatic event, then		Elementary/Secondary (0-12) College (1-4or 5+) Homemaker	Own Home																			
of Hea		F	F			1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Num Patrick D. Moroney/Son 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1 Removal from State 1 Injuny Cemetery, Sep. 11, 2005	ton, Va. 22124 20c. Location - City or Town, State														
Baltimer Pag Department Importent: Importent: any Injury of Once.		21. Signature of Funeral Partice Licensee Gary Downer 22. Name and Address of Facility Money & CC0508 171 W. Maple Ave., 23a. Part. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory	Approximate																			
760, Ite be executed /Medical Examiner // Assignment // As	Certification: To Be Completed by Physician/Medical Examiner	Be Completed by Physician/Medical Ex	Be Completed by Physician/Medical	Be Completed by Physician/Medical	Be Completed by Physician/Medical	Be Completed by Physician/Medical Ex	Be Completed by Physician/Medical Ex	Be Completed by Physician/Medical Ex	Be Completed by Physician/Medical Ex	Be Completed by Physician/Medical Ex	by Physician/Medical Ex	shock of heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Interval Between Onset and Death Years									
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Division To the Hospitel or Attention within 24 hours after death To the Funerel Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the composition of the basis of examination and/or investigation, in my opinion, death occurred at the time and member stated.	e, date and place, and due to the cause(s)																			
To T To COM	2	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	29d. Date signed (Month, Day, Year) Q-10-09 204, Frederick, Md.																			
Stat Registra	_	31. Date filed (Month, Day, Year) SEP 10 2009 32. Registrar's Signature SEP 10 2009	207, Frederick, ma.																			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #17 & 18 per FH 8895 9/15/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Regina Ann Macijeski **Physician** September 4 2009 1:12p M /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 7723 Wynbrook Road 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 80 166-22-1547 7,1929 Director March Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Baltimore Baltimore Director MD 1 □Yes 2 □Wo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 7723 Wynbrook Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify à Specify: White 3 Widowed 4 □ Divorced Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 12th marked other 18. Mother's Name (First, Middle, Maiden Surname)
Anna M. Miesler
Anna M. Misler 17. Father's Name (First. Middle, Last)

Joseph H. Thornton

Joseph Clark 12 should be fill h and Mental F 7 is marked otl Be traumatic e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
71 Hill Drive HAlifax PA 17032 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun Frances Clark /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 9/9/09 Baltimore MD 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC DISEASE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ORIGIN UNKNOWN ARCINOMA OF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence off. that the death certificate be executed and burial-tran Box 68760, Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) I∐Yes 2 ☑No P.0. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ≥ 1-17 PERTENSON 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate I 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2009 D0057948 PRIMART CARE PHYTICAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 BALTIMONE 21201 JANES TANSINDA PLACE SUITE 300 ARNSR7 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

Barks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🤈 🦳 🔍

		•	For State Registrar		State of M	ai yiai iu		tificate of		I WICITIAN	Reg. N			2000
	Physicia	an.	1. Decedent's Name (Fi	rst, Middle, Last						2. Date o Month		oay 20	ear_	3. Time of Death
_	/Medic				Coron		. McM	illon		9			09	4:00 p ^M
ź	Examin	er	4a. Facility Name (If not	institution, give	street and number))			or Location of De	ath	4	lc. County of	Death	
7			Rossvil 5. Social Security Numb	er 6. Se	or Care	je (In yrs. las	st hirthday)	Balto If Under 1 Year	If Under 24 H	rs. 8. Date o	f Birth	N/A	9. Birthp	lace (State or Foreign
	Funeral Director		213-34-842 Usual Residence of Dec	2.8	Эм 2 ∑ F	72	Yrs.	Months Days	Hours M	in. (Month	, Day, Yea -25-	1936	Coun	MD MD
	land ow			o. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	ith the Marylar or 28a-f show	į	MD	Balto		Ros	seda]	.e						1 XYes 2 □ No
	h the	irec	10e. Street and Number					10f. Zip Code			10g.	Citizen of Wh	at Coun	try?
	th wit	al D	2 Nancy	Court				212	37			U S	Α	
	ems	Jue	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of f Yes, specify Cu	Hispanic Origin? ban, Mexican, Pu	(Specify Yes of erto Rican, etc.	r No-	14. Race Black,	- Americ White, e	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medicul Examination must be multiled at once.	Be Completed by Funeral Director	1 ☐ Never Married 3 ☐ Widowed 4		1 ∐Yes 2 ∑ If Yes, Give Year or Dates:	Nο		I∐Yes 2∭INd	Specify:			Specify:	Bl	ack
2-0	72 hc	etec	15. (Specify o	Decedent's Edu	ication le com <i>pleted)</i>		16a. Dece	dent's Usual Occi kind of work done DO NOT use retir	ipation during most of i	vorking	16b.	Kind of Busi	iness/Ind	dustry
121	/ithin ine. han"	du	Elementary/Secondar	y (0-12)	College (1-4or							Unive	rsi	.ty
2	iled w Hygie ther t	ပိ	10th g1 17. Father's Name (Firs		N/A	1	НС	ousekee		lame (First, Mi	ddle. Maid	Hospi en Surname	tal	
anc	I be fi	Be	Isaiah F		ar.					s Bank		o., o.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Ž	hould id Me mark matic	2	19a. Informant's Name				19h Mailir	ng Address (Stree				v or Town. S	tate. Zip	Code)
, Ma	and 2 s ealth an n 27 Is ier trau		John B.				2 Na	ancy Co	urt Ros	sedale	, MD	2123	37	
Baltimore,	ages 1 ent of H tt: If Iter y or oth		20a. Method of Disposit 1	remation 3 🗆				sition (Name of natory or other pl emorial		Date -12-09		ndall		own, State
Ħ	nit. Partme oortan injur		21. Signature of Funera			ICI.		2. Name and Add	'	March				,
ä	any per) US	Land	0 20	ane	_ :	1101 E.	North	Avenu	е Ва	lto,	MD	21202
			23a. Part 1: Enter the d	isease, or comp	lications that cause ne cause on each I	d the death.	Do not ent	er the mode of d	ring, such as care	diac or respirate	ory arrest,			Approximate Interval Between
	Physician		Immediate Cause (Fina		•		1ACT	RUMTE	STINDE	BUE	EN			Onset and Death
	/Medical Examiner		resulting in death)		Due to (or as				-					
	Examiner	_	Sequentially list condition	ons,	b									
2	ted	nine	Sequentially list condition if any, leading to immediate. Enter Underlyin Cause (Disease or injust that initiated events	liate g	Due to (or as	s a conseque	ince or):							
NB	execurand and al-trar	Examiner	that initiated events resulting in death) Last		c Due to (or as	a conseque	nce of):						-	
68760,	tificate be executed g physician and as the burial-transit			·	d.									
89	g phy as the	edic										T T		
Вох		M/us	IF FEMALE: 23b. Was decedent pre	griant i	23c. If yes, outcome 1 ☐ Live birth			∃Ectopic pregna	nev			23d. Date		
_	Attending Physician: The law requires that the death cer death. r death. ector: After this certificate has been signed by the attendir by the funeral director, page 2 should be detached for use	by Physician/Medical	in the past 12 mor 1 □Yes 2 ØNo 9 □ Unknown	fths?	4 ☐ Pregnant 9 ☐ Unknown			Other (specify)			_	Mon	tn	Day Year
P.0	that the ed by detac	Ph	Part II. Other significer	nt conditions co	ontributing to death I	but not result	ing in the u	nderlying cause o	iven in Part I.	23e.	Did tobacc	o use contri	bute to t	he cause of death?
ds,	uires sign	d by									1 ☐ Yes	2 □ No 3	3□ Prol	bably 4 I Unknown
00	w req	Completed								24a.	Was an	24b. W	ere auto	opsy findings available ompletion of cause of
æ	The la	duc								_	autopsy performed	2/ de	eath?	mpletion of cause of 2 No
ta	an: T tification, pe		25. Was case referred	to medical					26. Place of	Death (Check o	res 2 🗷	NO I	□Yes	2 🗆 NO
Ξ	yslck is cer direct	o Be	examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 ☐ Inpat	ient 2 🗆 E	R/Outpatie	nt 3 DOA	ther:	g Home 5□		e 6 □Othe	r (Speci	fy)
0	ig Ph ter th	T:U	27. Manner of Death	□ Donding	28a. Date of Inj (Month, D	ury 2 av. Year)	28b. Time o	f 28c. In	ury at	28d. Desc	ribe how in	njury occurre	ď	
Ö	endlr sath. or: Af he fur	atic	2 ☐ Accident	Pending investigation					□Yes 2□No					
Division of Vital Records,	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification: To	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of In building, e	ijury - At hon tc. <i>(Sp</i> ec <i>ify)</i>	ne, farm, sti	eet, factory, office	ð	28f. Locat City o	ion <i>(Str</i> ee or Town, S	t and Numbe tate)	r or Run	al Route Number,
_	spital ours neral filled	CC	29a. Certiffer	Certifying Ph	ysician: To the bes	t of my know	ledge, deat	h occurred at the	time, date and p	lace, and due t	o the caus	e(s) and ma	nner as	stated.
	he Hos in 24 h he Fur pletely	edica	(Check only 2) one)	Medical Exam	Iner: On the basis and manner s		on and/or ir	vestigation, in m	opinion, death	occurred at the	time, date	and place, a	nd due t	o the cause(s)
	Vith To th	Ž	29b. Signature and title	of certifier	\sim			29c. Lice	nse number		29d.	Date signed	(Month,	Day, Year)
			MA	1 Cla	Ryse			100	06018		SET	7EMB	ER	9,2009
•	2		30. Name and address	of person who	completed cause of	death (Item:	23a) (Type, 7 H14	Print)	4 RN	#218	R	ALTIN	hore	9,2019 6,MA
	Sta	te	31. Date filed (Month, L		32. Regist	trar's ignatu	Bake		1 7	1	, '>	-) , ,		1
	Registr		SEP 1	0 2009	Deren	p. 19								

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		Ġ	Registrar Decedent's Name	(First Middle I	ast)						2.	Date of De		<u> </u>		3. Time	of Death
	ician dical		MARI	A	P.		ME	ERE	=		5	Month	31	ay Ye	9	43	DA M
	niner	4	a. Fecility Name (If	not institution, g	ive street and	number)		4b. Cit	ty, Town, o	r Location of Dea	ith		4	c. County of D	Death		
		L	Vantage						umbia		e 0	D-14 D:		loward	District	/Ctat	or Fornian
Funer Direct		5	577-42-8		Sex 1 □ M 2/(X)		yrs. last birthdi Yrs	Month	er 1 Year S Days	If Under 24 Hr Hours Mir		Date of Bi (Month, Di lar				land	e or Foreign
pus *		-	Isual Residence of 0a. State	10b. County		100	c. City, Town or	Location							10	Od. Inside	City Limits
a Maryla a-f sho	ctor		MD	Howard		(Columbi	a			.,						es 2 1 No
with the	Dire	1	0e. Street and Num 5400 Var		int Dd	#500		1	Zip Code				. 20	itizen of Wha ted St			
eath se 23	era	1		itage ro		ecedent Ever	in U.S. 1			Hispanic Origin? (Specif	/ Yes or N		14. Race - /			
Baltimore, North Stand 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23e or 28e-f show any injury or other traumatic event, the Modical Exp. (i. at man be notified at	Completed by Funeral Director	י	Marital Status Never Mame Widowed		Armed 1 ☐ Ye	IForces? es 2. ☑ No			pecify Cub 2⊠ No	lispanic Origin? (an, Mexican, Pue Specify:	nto Ric	an, etc.)		Black, V Specify:			
21215-0036 and within 72 hours affigiene.	leted		(Speci	15. Decedent's ify only highest		9 <i>d</i>)	/G	ecedent's Usine kind of	work done	during most of w	orking		16b.	Kind of Busin	ess/Ind	lustry	
within than	Ę		Elementary/Secon	ndary (0-12)	Colleg 4	e (1-4or 5+)		emake		/				Own Ho	me		
Hygi Hygi	ပိ	1	7. Father's Name (First, Middle, La			110111	- marco		18. Mother's Na	ame (F	irst, Middle					
pland uld be file Jental Hy rked oth	To B		Dominic	us Pauli						Irma Ba	uer	•					
d 2 shouth and N 7 is man			19a. Informant's Na Robert I			son)				and Number or F Ave. Bal							
1 and 1 and		2	Oa. Method of Disp				0b. Placa of Di	sposition (/	Vame of		Dete			Location - Cit			
ages ages int of t: If if			1 Burial 2	Cremation 3		om State	cometery, Chesape	,			009	,	Be	ltsvil	1e.	MD.	
Baltimore, semit. Pages 1 a Department of Her moortant: If them no injury or other	ei	-	21. Signature of Fu				Jiiebape			ess of Facility Ra		Funei					ervice
De per per per per per per per per per pe	DOCE		1 Dir	War	3	MOO	0982			Ave. Sil							
Physicia /Medic	al		23a. Part1. Enter the shock, or hear shock, or hear shock and shoc	rt failure. List or Final	a. Ta	on each line.				ng, such as cardi				Cy		Approxin Interval E Onset ar	Between
Examin	e e		Sequentially list cor f any, leading to im cause. Enter Unde Cause (Disease or that initiated avents	nditions, nmediate	b. Due	to (or as a co	nsequence of):	11		····							
'60, be executed sician and burial-transit	Examiner		Cause (Disease or that initiated avents resulting in death) L	injury Last	c	to (or as a co	nsequence of):							·- <u>-</u>			
760, ite be ex ysician	cal				d												
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death e atter	by Physician/Medic		23b. Was decedent in the past 12 1 ☐ Yas 2 ☐ 9 ☐ Unknown	months?	1	, outcome of p ve birth 2 regnant at time nknown	Fetal death	3 ☐Ectopic 5 ☐ Other		ey				23d. Date of Month		Day	Year
			Pert II. Other signif	icant condition	s contributing	to death but no	ot resulting in th	ne underlyin	g cause g	ven in Part I.				ouse contribu 2 □ No 3 [of death?
Records he law requires e has been sign	Completed											24a. Wa	s an	24b. We	re auto	psy findin	gs available of cause of
I Rec	E											per 1 Yes	formed:	dea	ith?	2 No	
of Vital F Physician: Th this cartificate	Be (1 :	25. Was case references	red to medical						26. Place of D	eath (Check only	one)	Vanl	4C	791	Sh _
- 8 S	2		1 Yes 2				2 ER/Outpa		LUA	her: 4 Nursing					(Specif	y)	
Jing After	atlon:		27. Manner of Deatl 1 □Natural 2 □ Accident	h 5 Pending investiga		ate of Injury Month, Day Ye	par) 28b. Tim Inju		28c. Inju Wo	iryat ork?]Yes 2 ☐No	28	I. Describe	now in	njury occurred			
- Par - C	edical Certification:		3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ad 280. P	lace of Injury - uilding, etc. (S	At home, farm Specify)	, street, fac	tory, office		28	. Location City or To		and Number ate)	or Aura	il Route N	lumber,
Hospital of 24 hours at a Funerel E	dical		29a. Certifier (Check only one)		caminer: On the		amination and/o			ime, date and pla opinion, death oc							se(s)
o the althin 2 or the comple	∑ e		29b. Signature and	title of certifier				- 1	29c. Licen	se number			29d. l	Date signed (Month,	Dey, Yea	r)
			> K	AAlor	lyn	1)			D5	3587	7		Sel	D+, 3,	20	09	<u>-</u>
151			30. Name and addr	ress of person w	ho completed	cause of death	(Item 23a) (Ty	(pe, Print)	KEN	WEST	f (561	1,1	200			
	State		31. Date liled (Mon	oth. CLYgar)	A 0000	2. Reg Krai	Signature	30-	>r	(0000)	LE	- 14	010	4100	1		
Rec	istrar			OFL T	U ZULIY	Was as a	4. 1	11	AD D								

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			Pleas	e Type or Pri						_		_	ible.		
		for State Registrar		Otato or mi	ai yiaii		rtificate			violitai i i	Reg. N	0,0	ne	2	2863
		1. Decedent's Name	e (First, Middle,	Last)						2. Date of D	eath	200	J 10 U	3. Time	e of Death
Physici /Medi		Leon	Bre	an Ma	alkin					Septem	ber	^{ay} 6, 2	2009	6:30	Ор. М
Examir		4a. Facility Name (I	If not institution,	give street and number)			, ,		Location of Death	ו	40	c. County	of Deat	h	
*				eral Hospit			Olney					Mont	gome	<u> </u>	
Funeral		5. Social Security N		5. Sex 7. Ag 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		la <i>st birthday)</i> Yrs.	If Under 1 Months D	Year Days	If Under 24 Hrs. Hours Min.	(Month, D	av. Year	2010	Co	hplace <i>(Sta</i> untry) w Yorl	te or Foreign
Director		578-42-9 Usual Residence of		**	98	110.				Nov. 2	.0, .	1910	Ne	W IOII	ζ.
yland yland		10a. State	10b. County			y, Town or Lo								10d. Inside	e City Limits
a-f st	ctor	MD	Montgo	mery	Si	lver S	pring							1 □ Y	′es 2ÑNo _
or 28	Dire	10e. Street and Nur	mber				10f. Zip Co				_		What Co	-	
ath w	Funeral Director	13600 St	oner Dr				2090						Sta		
er de	-nu	11. Marital Status	ted OT Mende	12. Was Decedent Armed Forces? d 1 □Yes 2 🛣	Ever in U.	S. 13.	Was Deceder If Yes, specify	nt of His Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or N o Rican, etc.)	10-		ce - Ame ick, White	rican Indian e, etc.	1,
Irs aft	by F	3 ☐ Widowed	ied 2 Marrie 4 Divorced	If Yes, Give Year or Dates:	140		1 □Yes 2X	No	Specify:			Specif	fy: Wh:	ite	
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Huddel Exprintment out the multiple at		10	15. Decedent's	Education		16a. Dece	dent's Usual (Occupa	ation	deim e	16b.	Kind of B	Business/	Industry	
thin 7 le.	Completed	Elementary/Seco		grade completed) College (1-4or !	ō+)	l .			luring most of wor)	King	Д,	-	0		
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be fill half half half half half half half ha	Be	17. Father's Name Max Mall		ast)					18. Mother's Nar	ne (FIFST, MIGGI			^{me)} ≀amov	i to	Brean
hould id Me mark matic	오	19a. Informant's N		n (Tyne Print)		19h Maili	na Address (S	Stroot s	and Number or Ru	ıral Boute Num				162	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Micdeal Examilier is ust be notified at once.				r / Daughte	r				Dr., Sil				_	904	
f Hea		20a. Method of Dis			20b. P		osition (Name matory or othe		-1	Date			- City or	Town, State	9
Pages nent o nt: If ry or			☐Cremation 3 5 ☐ Other (Spe	B Removal from State ecify)			e Crem		1 1	ot. 9,	Be	ltsv:	ille	, MD	
mit. partm porta y inju		21. Signature of Fu	^			2:	2. Name and	Addres	ss of Facility Ra	pp Fune	J				Service
8 3 5 8 8		Th	ACAM	8	M00	982	933 Gi	st	Ave. Sil	ver Spi	ing	, MD	209	10	
Physician /Medical		23a. Part 1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List or (Final	omplications that caused nly one cause on each line. a. Proposition of the proposition o	ne.	onic	ter the mode o	of dying	g, such as cardia	c or respiratory	arrest,				mate Between nd Death
Examiner		Sequentially list co	nditions.	b. Chron	vi C	Reno	al 1	ail	lure						
bed sit	Examiner	Sequentially list co if any, leading to im cause. Enter Unde Cause (Disease or	nmediate erlying	Due to (or as	a consequ	uence of):	A								
icate be executed physician and street transit	xar	that initiated events resulting in death)	5	c Due to (or as	a consequ	uence of):									-
te be /sicial				L _d .											
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Attending Physician: The law requires that the death certificate Ir death. r death. etcor: After this certificate has been signed by the attending physic by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 □Yes 2[9 □ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Feta	I death 3	☐ Ectopic pred ☐ Other (spec		/				ate of del	livery Day	Year
res that signed t	by Pl	Part II. Other signit	ficant condition	s contributing to death b	out not resu	ulting in the u	ınderlying cau	se give	en in Part I.	23e. Did	l tobacco	use cor	ntribute to	the cause	of death?
w require been si should t	ted									1 []Yes	2 No	3 🗌 Pı	robably 4	Unknown
law r nas be 2 sh	Completed									24a. Wa	opsy	24b.	prior to	itopsy findir completion	ngs available of cause of
: The cate h	Co									per 1 □ Yes	formed?	No	death? 1 ☐ Yes	2 □ No	
ician certifi ector	Be	25. Was case refer examiner?		Hospital:				Othe	26. Place of Dea						
Phys r this ral dir	년: -	1 ☐ Yes 2 ☐ 27. Manner of Deat		28a. Date of Inju		ER/Outpatie 28b. Time o	nt 3 DOA	1	4 LI Nursing F	lome 5 ☐ Re 28d. Describe			, ,	cify)	
th. : Afte	tion	1 Natural 2 ☐ Accident	5 Pending investiga	(Month, Da	ay, Year)	Injury	М	. Injury Work 1 □ \	? Yes 2 □No			,,			
Atter or dea ector by the	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin		ury - At ho	me, farm, sti	reet, factory, o	office		28f. Location City or T			ber or R	ural Route I	Number,
ital or irs afte ral Dir		Torriotte													
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check only one)		Physician: To the best xaminer: On the basis of and manner st	of examina										se(s)
Vithi To th	Ž	29b. Signature and	Title of certifier						e number		29d. E	Date sign		h, Day, Yea	ar)
,=			Vacil	MD			MD	00	6 80 26	0	O	7/08	3 2	009	
41		30. Name and add	ress of person w	ho completed cause of	death (Item		Print)	.1 i>	De C	LNEY	m	ð	20	832	
Sta		31. Date filed (Mon	SFD 1 A	32. Registi	ar's Signa	ture		ĥ							
Regist	air		API TO	LUUJ LENE	u	1. 1	BRARAS	/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / 1 - State Registrar	•	ificate of L		_	g. No. 7 () () ()	28864
	Physici	an	1. Decedent's Name (First, Middle, Last) Lucy 0. Mur	nha			2. Date of Death Month	Day Year 5, 2009	3. Time of Death 10:30 P ^M
4	/Medic		Lucy 0. Mur 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	sept.	4c. County of Death	
	Examin	er	Brighton Gardens of Tuckerman		Bethe	sda		Montgo	omery
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 ☒ F 7. Age (In yrs. last. 88	birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept • 2	Year) Cou	place (State or Foreign intry) V York
	land Dw		Usual Residence of Decedent 10a. State 10b. County 10c. City, To.	own or Loca	ation				10d. Inside City Limits
	Mary a-f she livet	tor	MD Howard		Columb	ia			1 □Yes 2X No
	h with the	al Director	10e. Street and Number 6500 Freetown Rd.		10f. Zip Code	21044	10	Og. Citizen of What Cou United Sta	
21215-0036	'natural', or items 23a or 28a-f show "dell Exprimet nust be indiffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married In Yes 2 No If Yes, Give Year or Dates:		as Decedent of Hi Yes, specify Cuba □Yes 2 XNo	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
2	72 ho natur fical	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Decede	ent's Usual Occupa	ation furing most of worki)	ing	6b. Kind of Business/I	ndustry
121	C - M	mpl	Elementary/Secondary (0-12) College (1-4or 5+)		O NOT use retired _. oker)		Real Esta	nto.
Q 2	e filed withing Hygiene. other than yent, Ire M		17. Father's Name (First, Middle, Last)		OKEI	18. Mother's Name	e (First, Middle, M		1100
au		To Be	William Ohler			Lucy	V	itt	
Maryland	12 shout hand hand hand hand hand hand hand hand			_		and Number or Run ${f r.,\ High}]$		City or Town, State, Z	ip Code)
ore,	S to #		20a. Method of Disposition 20b. Place cerne	e of Disposi	ition (Name of atory or other place	e) [Date 2	20c. Location - City or T	Town, State
Ĕ	Pages ment of I ant: If ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) Unifo	rmed	Services	Univ. 9/		Bethesda,	, MD
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenses Moo 38.	2 Ra 93	Name and Addres pp Funer 3 Gist A	es of Facility al and Cr ve., Silv	remation ver Sprim	Services	910
			23a. Part 1. Enter the disease, or complications that caused the death. E shock, or heart fallure. List only one cause on each line.						Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence)		NEMLA				Onset and Death
	Examiner	<u>_</u>	Sequentially list conditions, b. 192018TR	EM	A				
	ted nsit	nine	Sequentially list conditions, if any, locuring to the redistrictures. Enter Underlying Cause (Disease or injury	ce on					
<u>,</u>	ifficate be executed g physician and as the buriai-transit	Examiner	that initiated events c. Due to (or as a consequence	ce of):					
68760,	ysicia ysicia	edical	d						
O. Box 68	ath cert	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat	eath 3 🗆	Ectopic pregnancy Other (specify)	у		23d. Date of del Month	ivery Day Year
σ.	that the de ned by the a detached f		Part II. Other significant conditions contributing to death but not resultin	ng in the un	derlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rds	w requires that s been signed t should be deta	d by					1 □ Ye	s 2 <mark>X</mark> No 3□ Pr	obably 4 ☐ Unknown
000	aw rec is bee 2 shou	Completed					24a. Was ar	24b. Were au	topsy findings available completion of cause of
Ĕ	The late ha	Com					perform	ned? death?	2 🗆 No
/ita	yslclan: The law nis certificate has t director, page 2 sl	Be	25. Was case referred to medical examiner?		l out	26. Place of Deat	h (Check only on	9)	
n of Vital Records,	ding Physl h. After this c funeral dire	on: To	1 Natural 5 □ Pending (Month, Day, Year)	N/Outpatient Bb. Time of Injury	28c. Injur Work	y at		ence 6 Other (Special Other (Special Other)	cify)
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre		Yes 2□No	28f. Location (St City or Town	reet and Number or Ru n, State)	ural Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tire estigation, in my o	me, date and place ppinion, death occur	, and due to the c rred at the time, d	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	To the within 2. To the I complete	Me	29b. Signature and title of Contrier		29c. Licens	e number	2	9d. Date signed (Monti	h, Day, Year)
			I thank M.D		D30	0032		9-8-0	59
	5V		30. Name and address of person who completed cause of death (Item 23	_	Print)		-	Wices MD	0
	20		MATASHANITO GILOSH MO 1481	2 PH	YSICIANS	LU # K	2 Keek	WILLE ME	20050
	Sta Registi		31. Date filed (Month, St. Frag. 2009) 32. Registrar Signature	8	8				
DH	MH 17 Rev 1/2		Justine 1	J. 18	arely				

ORIGINAL

09-06895 Ron

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

				e oi w	•	Car	tificate	of I	Death				Ren	j. No.	9	1111	3 9886
		Den	or State strar				incate	, 0, 1				2.	Date of Death		-	3. Tii	ne of Death
Physicia		1. [ecedent's Name (First, Middle,L		-				367				Month September	Day 3, 200	Year)9	1	548 hrs
dical Exami					onald		e	146	Mau1 . City, Tow	m orlo	cation of I		ooptonie o.	4c. C	ounty of I	Death	
			Facility Name (if not institution,		et and num	ber)			Dundal		outron or .			Bal	timore	County	į.
			Rear of 2009 Paulette R	.oad							If Under	2/Hrs	8. Date of Birth	n(MM/DE	CYYYY	9. Birthplac	e (State or
Funeral		5. 8	Social Security Number 6.	. Sex	7	. Age (In yrs. I	ast birthda	ay)	If Under 1	Days	Hours	Min.			- 11	-oreign	
Director	ı	2	19-40-9044	XM	2 F	64		Yrs.	MOUTUS	Days	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Feb.	16,1	945	Country)	MD
	- 1	Lici	ual Residence of Decedent													100	Inside City Limits
áu	- 1	_	a. State 10b. County			10c. City	Town or	Locatio	n								Yes 2 X No
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with ms 2	era		Marital Status		Armed Fo	edent Ever in U	.5.	If Ye	s, specify	Cuban,	Mexican,	Puerto F	ticán, etc.)		White,	etc.	i i
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. red other than "naturial", or items 23a or 28a-f show any rent, the Medical Examiner must be notified at once.	Funeral	1	Never Married 2 XMar	172	Yes	2 No	Ì		Yes 21X	No	enecify:			s	Specify:	Whi	+0
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ours atur xami	ğ	1	5. Decedent's Education (Speci				16a. De	iring mo	st of worki	ing life.	DO NOT	se retire	ed)				
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036 Irthin	ďμ	1	12 Years					Fina	incia	<u>I P.</u>	Lanne Mother's	Name	(First, Middle,				
5-0 ed w tygie othe	ပိ	17	'. Father's Name (First, Middle, I								O.WOUTET	, raino					ŀ
21215-0036 21215-0036 Juld be filed within 7 I Mental Hygiene. I marked other than ic event, the Medica	Be		John Henry Mau				1		5 1 1	(0):	and Num	hor or P	Marga urai Route Nur	mher. Cit	v or Towr	n, State, Zir	Code)
AD 21 2 should by and Mer 27 is manuatic ev	<u>۵</u>		a. Informant's Name/Relationsh														
ore, MD 21215-0036 ss 1 and 2 should be filed within 72 hours after of Health and Montal Hygiene. If item 27 is marked other than "natural", then tranmatic event, the Medical Examiner.			Mrs. Diana L. N	lau1	(Wi	fe)	بل	202.	5 Pau ition (Nam	Let	te Ko	aa A	Apt. 2 Date	720c. L	ocation -	City or Tov	
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lor ages ages of the office of the of the office of the of	l		X Burial 2 Cremation		Removal II	om State			Ceme	ter	y	9	/8/2009) <u> </u>	Balti	more,	Maryland
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Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum			1. arguature of Funeral Service					Du	da-Ku	ick	Ave	Du	ndalk.	Mar	vlan	7 21	222
	-		Ba Part I Enter the discase, or	complicat	tions that o	aused the dea	th. Do no	enter t	he mode o	of dying,	such as c	ardiac o	r respiratory ar	rrest, sho	čk, or he	art	Approximate Interval Between Onset and
Physiciar /Medica		1	failure. List ont one cause	011 000		D			d cut	-+in	a in	inri	a c			}	Death
amine			nmediate Cause (Final disease or condition resulting in death)		wning	D FOV		an	<u>a cui</u>	LLII	<u> </u>	<u> ur r</u>	<u> </u>				
		١	r condition resulting in death)	Due	to (or as	a consequence	. 01).										
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Box 6871 death certification by the attending pure	3		3b. Was decedent pregnant in the past 12 months?	ne		birth jnant at time o			etal death	3	Ectop	ic pregn	arroy				•
th ce	9		1 Yes 2 No 9 Un	known	9 Unk		douth (5 C	other (Spe	еспу)				- 1			
Be deg		ڇٰا	Part II. Other significant condi				ot resultin	a in the	underlying	g cause	given in F	Part I.					e cause of death?
that th		5	Part II. Other significant condi	.:	on mounting	. dicas	CA	3	,	•			1 🗆 ነ	Yes 2	✓ No 3	Proba	bly 4 Unknown
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hysicia /Medic		1. Decedent's Name (First, Middle, Last) POROTHEA JEAN MOO	RE	2. Date of Death Month	2 8 200	3. Time of Death 9 106 A
/wedic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	nth
		120 Patricia Avenue	Linthicum If Under 1 Year If Under 24 Hrs.	9 Date of Birth	Anne At	
uneral rector		5. Social Security Number 216-30-9418 Contact Security Number 1 M 2 Ten Ten Security Number 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day, Y) 08-24-19	(ear) C	rthplace (State or Foreign ountry) MD
-f show	tor	10a. State 10b. County 10c. City, Town or Lo MD Anne Arundel Linthicu			-	10d. Inside City Limits 1 □ Yes 2 🖫 No
r 28a	irec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What C	ountry?
23a o	alD	120 Patricia Avenue	21090		U.S	.A.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be inclined at once.	by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puert 1 □Yes 2∏ No Specify:	pecify Yes or No- o Ricen, etc.)	14. Race - Am Black, Whi	
"natura edical E	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king	b. Kind of Business	s/Industry
the M	mo d	Flomentary/Secondary (0-12) College (1-4or 5+)	cal Transcription:	ist	Hospit	al
other vent,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Ma	iden Surname)	
arked atic e	고 E	Joseph Hunger	Edna	Mason		
tem 27 Is ma other trauma			ng Address (Street and Number or Ru 45 Drevar Trail	aral Route Number, C Annapolis		Zip Code) 401
ant: If iter ury or oth		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Dispocemetery, cremation State Dorcheste	osition (Name of matory or other place) er Mem. Park 09-1		oc. Location - City o Cambridge	
Importa any Inju once.			2. Name and Address of Facility 1 Singleton Funeral			Burnie, M ces, PA
physician and edical miner transit the purial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it also leads cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	C GASTRIC	LANCE		Onset and Death
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s been signed by should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.			to the cause of death?
ate has	Completed			-	prior to death? 2N0 1 □ Ye	autopsy findings availal o completion of cause o es 2 □ No
	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Other:	ath <i>(Check only one)</i> Home <u>5</u> Residen		agoifu)
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Direct in by	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or i State)	Rural Route Number,
To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occur	e, and due to the car urred at the time, dat	use(s) and manner te and place, and d	as stated. ue to the cause(s)
To th	Me	29b. Signature and title of certifier	29c, License number D 47934 Print) PAOL PL BAL	e 290 S	d. Date signed (Mo.	nth, Day, Year)
			211			

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AMEND TIEM# / PerFH, 6895, 9/10/09, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear Emma Katherine Mead 2:00 A M Sept. 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Stella Maris Timonium Baltimore 8. Date of Birth (Month, Day, Oct. 11 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs ^{Yea}r) **1922** Hours 1 □ M 2 □ Days Months 217-18-5217 87 86 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐Yes 2 No **Baltimore Timonium** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2300 Dulaney Valley Rd. 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Xo Specify: white Specify: 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Beautician Beauty 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert E. Wagner Emma K. Simpson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James McDairmant/son 11975 Homestead View Ct., Worton, MD 21678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 Removal from State Dulaney Valley Memorial Gardens Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093

Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc. 21. Signature of Funer Michael lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, see cause on each live. 23a. Part Enter the Iseas shock, Theart failure. Approximate Interval Between Onset and Death BSTONEBUL days VISEON Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

Director

Funeral

by

Completed

Be

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MD

Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Medical Evanings must be notified at once.

and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

SEPTEMBER

the Hospital or Attending Physician:

of Vital Records, P.O. Box 68760,

Division

KATHERINE

filled in by the within 24 hours a To the Funeral I

lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Line Underthing Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
ysician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ♣ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopi 4 ☐ Pregnant at time of death 5 ☐ Other 9 ☐ Unknown	c pregnancy (specify)	23d. Date of de Month	elivery Day Year
Completed by Physician/Medical	Part II. Other significant conditions Stage Stage Male and	contributing to death but not resulting in the underlying some source of the source of	g cause given in Part I.	autopsy prior to performed?	
Be (25. Was case referred to medical		26. Place of Death (Check only one)	
	examiner? 1 ☐ Yes 2 ☐ 🙀 o	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: A Nursing Home	e 5 ☐ Residence 6 ☐ Other (Spe	ecify)
ation: 1	27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M		d. Describe how injury occurred	
Certification: To	3 ☐ Suícide 6 ☐ Could not be determined		ory, office 28	f. Location <i>(Street and Number or Ri</i> City or Town, State)	ural Route Number,
Medical (29a. Certifier General Suppose Check only one) Check one) Check one) Check only one) Check	hysician: To the best of my knowledge, death occurr iminer: On the basis of examination and/or investigat and manner stated.	red at the time, date and place, ar ion, in my opinion, death occurred	nd due to the cause(s) and manner a d at the time, date and place, and du	s stated. e to the cause(s)
ž	29h Signature and title of contifier	1 1 -	29c. License number	29d Date signed (Mon	th Day Year)

29d. Date signed (Month, Day, Year) SEPTEMBER 8, 2009

TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

State Registrar

29b. Signature a

EDDIE NAKHUDA,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's S

 $M \cdot D$

2300 DULANEY VALLEY ROAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** J. **McGRAW** September 2009 6:15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Brooklyn Park GUARDIAN ANGEL ASSISTED LIVING 8. Date of Birth (Month, Day, Ye If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1925 Days 1 □ M 2 🗹 F Months Hours Min. Maryland 214-20-3072 83 Director Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State la or 28a-f show 28a-f show 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 U.S.A. 1632 Wall Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ģ Specify: 3 M Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental tem 27 is marked or Ruth Glee J. Ha11 Benjamin ٩ other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1632 Wall Drive, Pasadena, Maryland 21122 Sandra L. Schwind-Walsh (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If it any Injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park Sept. 9,2009 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service License 3204 Mountain Road, Pasadena, Maryland 21122 23a. Prt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each, line. Approximate Interval Between Onset and Death mediate Cause (Final ement **Physician** isease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed the burial-trai resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by of Vital Records, 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No certificate ⊺∐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 \sum Nursing Home 5 \sum Residence Living 1 Yes 2 Vo 1 Inpatient 2 ER/Outpatient 3 DOA 6 ☑ Other (Specify) Medical Certification: To completely filled in by the funeral 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation after death. 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar 29b. Signature and title

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** MELVIN THOMAS **MYERS** :25-PM Jentenuber. 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Buen ANNe GLEN BAltimore Medical Center Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, April 5, Social Security Number 9. Birthplace (State or **Funeral** 216-42-2278 Months Days Hours Min. 1**M** M 2□ F Maryland 1944 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any Injury or other traumatic event, I'm Medical Examiner must be notified at 1 ☐ Yes 2 INO Director Anne Arundel Pasadena Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21122 1909 Poplar Ridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 🗷 No Specify: 2 3 ☐ Widowed 4 💆 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed 12 Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Straub Magdallen Emerson Myers ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1909 Poplar Ridge Road, Pasadena, Maryland 21122 Gloria M. Manges (Sister) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State Bayview Crematory Sept. 8, 2009 |Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McCully Polyniak Funeral Home P.A. us) 3204 Mountain Road, Pasadena, Maryland 21122 Prt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner JCEPARLORAP Sequentially list conditions, any locality to instruct the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed PLICONTA ned by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 24 No 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ဥ 1 ☐ Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: 27. Mann of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 ☐ Pending investigation ithin 24 hours after death.

the Funeral Director: A
pmpletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier t Cruifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 To the I 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAZOMONO meDICH 123 HING-10)

State Registrar 31. Date filed (Month, Day, Year)

NeRS

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 2009 BERNARD MANEKIN

Physician /Medical Examiner

physician and s the burial-transit attending | for use as been signed by the should be detached has funeral dir death. filled in

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 3704 N. CHARLES STREET, #1506 BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/04/1913 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 212-01-4565 1**X** M 2 □ F 95 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medical Expander must be 1 3704 N. CHARLES STREET, #1506 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: þ 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)
5+ REAL ESTATE EXECUTIVE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY MANEKIN ဂ္ 19a. Informant's Name/Relationship (Type. Print) RICHARD MANEKIN / SON 20a. Method of Disposition 2AIR Plate of the position (Name of Nace) Date permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State AMUNO CONGREGATION 09/08/2009 4 ☐ Donation 5 ☐ Other (Specify) Signature uneral Service Licensee bem 23a. Part i. Enter the disease, or complications that eauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cardiac disease or condition resulting in death) Arrythmio /Medical Due to (or as a consequence of) Examiner Rend Acute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Dehydration Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dementia IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy ☐ Live birth 2 ☐ Fetal death in the past 12 months? Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ heart disease chrovasevin assident 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation al or Attend s after death I Director; 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 019914 9/7/09

SILVERSTEIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 RAISIN TREE CIRCLE, BALTIMORE, MD 21208 20c. Location - City or Town, State BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Litherville md

DHMH 17 Rev 1/2001

State Registrar

-ratifine mo 31. Date filed (Month, Day,-Year) -

30. Name and address of person

32. Registrar's Signature 1. parket

Rd

who completed cause of death (Item 23a) (Type, Print)

10753 Fall

3. Time of Death

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

1**X**□Yes 2 □ No

4c. County of Death

USA

14. Race - American Indian, Black, White, etc.

Specify: WHITE

<u>REAL ESTATE</u>

N/A

10:55 PM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #2, per MD 8895 9/10/09 TT

			For State Registrar	State of Mai	ryláno	-	rtment of I tificate of		Mental Hy	giene Reg. No.		
			Decedent's Name (First, Middle, Last)				-		2. Date of Month		2009	3. Time of Death
	Physici: /Medic		NATHANIEL MACKE	L						75 TOAY	3 Z	820PM
	Examin		4a. Facility Name (If not institution, give s	street and number)			4b. City, Town, o	or Location of Death		4c.	County of Death	
we th		м	SEASONS HOSPICE				AL RAND If Under 1 Year	ALLSTOWN If Under 24 Hrs.	O Data of Bi	utla	BALTI	
	Funeral Director		5. Social Security Number 6. Sex 1X	IM 2□ F	(in yrs. ia 80	st birthday) Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, Di 8-1-19		Cot	place (State or Foreign Intry) LAND
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Loc	ation					10d. Inside City Limits
	Maryla f sho	ro	MD. N/A			ALTIMO						1X□Yes 2□No
	r 28a-	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Cou	intry?
	h with		1510 W. MOSHER	ST APT 7A			212	17			USA	
	r dear	Funeral		2. Was Decedent Ev Armed Forces?	er in U.S	3. 13. V	Vas Decedent of I	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	D	14. Race - Amer Black, White	
36	I within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show tta Medical Examinat must be notified at	by Ft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:			□Yes 2√∑No	Specify:	, ,		Specify: BL	
5-0036	2 hou		15. Decedent's Educ	eation	- 1	16a. Deced	ent's Usual Occu	pation		16b. Kii	nd of Business/li	ndustry
215	thin 7, e. an "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)		(Give I life. D	kind of work done OO NOT use retire	during most of word d)	king	1		
21	e filed within 7 al Hygiene. other than "r oent, Ire Med	Con	-12-	4		MILI	TARY				OVERNME	T.
and	0 0 - >	Be	17. Father's Name (First, Middle, Last)	G.D.				18. Mother's Nan		, Maiden	Surname)	
Maryland	should be filed and Mental Hygi s marked other umatic event, I	2	JAMES H. MACKEL 19a. Informant's Name/Relationship (Type)			19h Mailin	n Address /Street	ELLA H		er City o	r Tawn State 7	in Cada)
	d2 ltha 27 is trau		JANICE OUARLES	,		· ·	,	RE RD. RA		, ,		,
Je,	it. Pages 1 and 2 should b ritment of Health and Ment ritant: If item 27 is marked njury or other traumatic e		20a. Method of Disposition	<u>.</u>	20b. Pla	Lace of Dispos metery, crem	sition (Name of latory or other pla	ce) 9_11	Date 2009	20c. Lo	cation - City or T	own, State
Ĕ	~ = =		ty Burial 2/17 Cremation 3 □ R 4 □ Donation 5 □ Øther (Specify)	emoval from State	l		FOREST V	i		OWIN	GS MILLS	MARYLAND
Baltimore,	permit. Pag Department Important: l any injury c		21. Signature & Emeral Service License	JONATHAN	D. I			ess of FacilityVER				SERVICE LAND 21217
	-		23a. Part Enter the disease, or complic	cations that caused th	ne death.						i intiti	Approximate Interval Between
	Physician		shock, or heart failure. List only on Imme the Cause (Final	e cause on each line.	-10	- 0	Oncor					Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	conseque	ence of):	ancer					
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	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Linto runarying Cause (Disease or injury that initiated events	Due to (or as a	conseque	ence of):						
	executed n and ial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	conseque	ence of):						
20/	icate be executed physician and s the burial-transit	edical	€ d									
20	ertifica ing ph s as th	Med	IF FEMALE:									-
X Q Q	ath ce	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	Fetal of	death 3	Ectopic pregnanc	су		2	23d. Date of deli Month	very Day Year
j	the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown	me of de	eath 5∟	Other (specify) _					
7. 7.	s that ned b	by Ph	Part II. Other significant conditions con	tributing to death but	not resul	ting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
	equires en sig								10	Yes 2[□No 3□Pro	bably 4 Unknown
ecords,	law re as be 2 sho	Completed							24a. Was			opsy findings available ompletion of cause of
ř	The cate h	Som							auto perfo	ormed?	death?	2 No
VITA	ician; sertific ector,	Be (25. Was case referred to medical examiner?				Tai	26. Place of Dea	th (Check only	one)	es i s A	2 - A H-0116
0	Physic ral dir	<u>۹</u>	1 Yes 2 No	ospital: 1 ☐ Inpatient 28a. Date of Injury		R/Outpatient	3 LI DUA				Other (Spec	SONS HOSPIC
0	ding th. After funer	ţi	1 Natural 5 Pending 2 Accident investigation	(Month, Day,		Injury	28c. Inju Woi M 1 [ryat rk?]Yes 2 □No	28d. Describe	now injury	y occurred	
vision	Atten r deal ector: by the	ifica	3 Suicide 6 Could not be	28e. Place of Injury	At hon	ne, farm, stre			28f. Location	Street and	d Number or Ru	al Route Number,
5	tal or rs afte al Dire	Certification:	4 Homicide determined	building, etc.	(ъреспу)				City or To	wn, State))	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of e and manner state	xaminati	rledge, death on and/or inv	occurred at the t estigation, in my	me, date and place opinion, death occu	, and due to the rred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)
	To the vithin To the compl	Me	29b. Signature and title of certifler				29c. Licens	se number		29d. Dat	e signed (Month	, Day, Year)
			> De Dulle	Burlo	7		H	45931		SEPT	EMBER	3 Zag
			30. Name and address of person who con	mpleted cause of dea		23a) (Type, F	Print) OLD Cor	KT RD	Randa	11stm	mMD	. 3 Zad
	Stat	te	31. Date filed (Month, Day, Year)	32. Registrar's				, 10		100		
	Registra	ar	SEP 1 0 20	no Mener	1	1. B	arkal					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	amend #5 Perate Uf May Jand 400 Par 1 - For Certif	tHent of Health and Nificate of Death		ene g. No.2 (11) 9	23872
Physiciar /Medica	۱, ا	1. Decedent's Name (First, Middle, Last) OCCO	ccormich	2. Date of Death Month	Day Year	3. Time of Death
Examine	r	,	sb. City, Town, or Location of Death Baltimore City		4c. County of Death	
Funeral Director			If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 9 (Month, Day)	9. Birth Con Wash	nplace (State or Foreign intry)
laryland f show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locat MD Anne Arundel Glen Bur				10d. Inside City Limits 1 Yes 2X No
with the Man or 28a-be notified	Direct	10e. Street and Number 8 Oak Lane, NW	10f. Zip-Code 21061	10	g. Citizen of What Cou USA	untry?
Mam xam	D La	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Ves 2 No.	as Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036 d within 72 hours aft grene. Then "natural", or the Medical Examir	Сошріете	(Specify only highest grade completed) (Give kir life. DC)	nt's Usual Occupation and of work done during most of work NOT use retired) nsulting	king	self-emplo	
Maryland 2121. 12 should be filed within " h and Mental Hygiene." 7 is marked other than " traumatic event, the Med	0 Be C	17. Father's Name (First, Middle, Last) Perry McCormick	18. Mother's Nan Marjo	ne (First, Middle, N rie Fels		
, Maryland and 2 should be file eath and Mental Hy marz is marked oth the traumatic event,			Address (Street and Number or Ru Lane NW, Glen Bu			ip Code)
Baltimore, M permit. Pages 1 and 2 Department of Health important: If item 27 important: If item 27 important: If item 27 important: If item 27 important: If item 27 important: If item 27 important: If item 27 important: If item 27 important: If item 27 important: If item 27 important: Item 20 imp		20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposit cemetery, crema Metro Crem	tory or other place)		20c. Location - City or atonsville	
Baltimore permit. Pages 1 Department of F important: if ite any injury or ot		42.	Name and Address of Facility Kin l Crain Hwy SE G	len Burni	Le MD 21061	al Home
Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition	the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
)/Medical Examiner		resulting in death) Due to (of as a consequence of):		٠		
3760, sate be executed hysician and the burial-transit	Ехап	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):				
	/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	livery
ecords, P.O. Box 68 aw requires that the death certifics is been signed by the attending ph 2 should be detached for use as 1	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 3 1	Ectopic pregnancy Other (specify)		Month	Day Year
ds, P.O.	ò	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tob	oacco use contribute to s 2 ☑ No 3 ☐ Pr	o the cause of death?
I Records, P.O. Box 68. The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Completed			24a. Was an autops perform	y prior to	utopsy findings available completion of cause of
of Vital Physician: Th this certificate real director, pa	lo Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No Hospital: 1 \(\text{Inpatient} \) 1 \(\text{Inpatient} \) 2 \(\text{ER/Outpatient} \)	Othor	th <i>(Check only one</i>		cify)
ion of iding Physical After this efuneral d		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe ho	ow injury occurred	
Division of Vital Reform to the Hospital or Attending Physician: The lightin 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)		Cify or Town,		
To the Hospital	Medical	29a. Certifier (check only one) 1. Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investigation and manner stated.	occurred at the time, date and place estigation, in my opinion, death occur	e, and due to the courred at the time, d	ause(s) and manner as late and place, and du	s stated. le to the cause(s)
To the To the Comple	Me	29b. Signature and title of certifier **Acoubset, MD	29c. License number 2E5 — 000	1	9d. Date signed (Mont	h, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint)			ore, MD, 21287
State Registra		31. Date filed (Month, Day, Year) SED 1 0 2000 32. Registrar's Signature		1101111 1101	.o o., baitin	,, 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician $//\sim$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLUMBIA HOWARD COUNTY GENERAL HOSPITAL HOWARD Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1**▼** M 2□ F Months Days Hours 214-72-8467 52 Director MARYLAND 4-10-1957 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examina must be notified at 10a. State 10b. County 10c. City. Town or Location Director MD. HARFORD 1 √Yes 2 No ABINGDON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3330 CHEVERLY CT 21009 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify þ Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SLITTER OPERATOR FACTORY Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MELVIN MADDEN EVELYN MADDEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a SHARON HAYWOOD (WIFE) 3330 CHEVERLY CT. ABINGDON, MARYLAND 21009 item 27 other t 20a. Method of Disposition 1 Burial 2 Crematic 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date = 5 3 Removal from State permit. Page Department of Important: If any injury or once. 4 ☐ Donatio 5 Other (Specify) GARRISON FOREST VETERANS 9-16-2009 OWINGS MILLS, MARYLAND HIBN R2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. D. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 th. Enter the disease, or complications that caused the death. ck, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory Immed te Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a ☐Yes 2 ☐No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has bage 2 s autopsy within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page 1 ☐Yes 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 - Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, or Attending Physician: within 24 hours a the Hospital

P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

29a, Certifier

SUIL 32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

HIMI)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	State of Marylar		nt of Health and	Mental Hygien	2007 200	374
	Physici /Medi		1. Decedent's Name (First, Middle, La	E NEBL	ETT		2. Date of Death Month	3. Time	of Death
,	Examir Funeral Director		4a. Facility Name (If not institution, given the following of the following of the facility Number of Number of Number of Number of Numbe	RE HOMEL	NOOD	y, Town, or Location of Deat PALTO; er 1 Year If Under 24 Hrs s Days Hours Min	8. Date of Birth	9. Birthplace (State	or Foreign
	Maryland	tor	10a. State 10b. County	10c. Ci	ty, Town or Location			10d. Inside (City Limits
	ath with the 23a or 28	ral Director	10e. Street and Number 2700 CHARL	ES ST.		ONK.	10g. C	Citizen of What Country?	
9036	172 hours after death with the Maryland "natural", or items 23a or 28a-1 show salical Examinat must be notified at	d by Funeral	11. Mafital Status 1 ☐ Never Married 2 ☐ Married 3 Ø Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 20 No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK	
21215-0036	within 72 ane. than "nai	Completed	15. Decedent's Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of v life. DO NOT	vork done during most of wo use retired)	rking 16b.	Kind of Business/Industry HOUSE	
Maryland		To Be (17. Father's Name (First, Middle, Last, BR 15) 19a. Informant's Name/Relationship (BON	19h Mailing Addre	18. Mother's Na FLL ss (Street and Number or R	me (First, Middle, Maide P Sm 1 TT	4	
_	1 and 2 s Health ar em 27 is ther treu		DEPT OF AGE, 20a. Method of Disposition	VE MR SHOW	Place of Disposition (A	LVERT S	T. BALTO.	- 111	
Baltimore	permit. Pages Department of it important: If its eny injury or o		1 ☐ Burial 2 D Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifications) 21. Signature of Funeral Service Licer	()	LANTIC 22 Name	and Address of Facility	77. 2609 C	LENBURN	E MY
ŗ	Physician /Medical Examiner		23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. One to (or as a consec	sular,	ode of dying, such as cardia	c or respiratory arrest,	Approxim Interval Br Onset and	etween
8760,2		Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Lus to (or as a consected.	quence of):				
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous forms of the continuous forms of	al death 3 Ectopic			23d. Date of delivery Month Day	Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacco	ouse contribute to the cause of	f death? Unknown
Œ	The ate h page	Completed					24a. Was an autopsy performed?		
Z.	Physician: Th this cartificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Ispio	Othor	ath [Check only one]		
on of	ding Phy h. Alter this funeral d	tion: To	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	dome 5 Residence 28d. Describe how in		
	To the Hospitel or Attending Phys within 24 hours alter death. To the Funeral Director After this completely filled in by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined		ome, farm, street, facto		28f. Location (Street and City or Town, Sta	and Number or Rural Route Nu te)	mber,
	To the Hospital of within 24 hours at To the Funers! D completely filled in	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. nd place, and due to the cause	ı(s)
	To t Comp		29b. Signature and title of certifier	nyá	2	9c. License number 37	29d. D	Date signed (Month, Day, Year) 2-08-09	
50-	2		30. Name and address of person who DAR CH AN S	completed cause of death (Iter	m 23a) (Type, Print) 00 W . M 0 U	NT Royal AV	4, Baltin	ou MD 212	17
	Sta Registr		31. Date filed (Month, Day; Year) CED 1 0	32. Registrar's Signs	ature -				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29c & d. per Mn G895 9/10/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 5ept arke 2009 1:05 AM onia Medical ne (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Baltimore tospice owson . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 Months Days Hours Min. D(Month 2014, 1998 26 219-02-8932 Director or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore 1 ¥Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Q Funeral 21239 USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give marked other than "natural", 3 🗌 Widowed 4 🗌 Divorced Blac Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working _____life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Callege (1-4 or 5+) should be filed within and Mental Hygiene. le mar (e-Veax Be 17. Father's Name (First, Midgle, 18. Mother's Name (First, Middle, Maiden Surnar 2 eroin orma Informant's Name/Relationship (permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m 21202 $\mathcal{M}\mathcal{D}$ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) lark 21. Signature of Funer Service Licensee ees 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onget and Deat Carcinon Physician/ disease or condition resulting in death) Medical Due to as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 本名 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy 5 Other (specify) Pregnant at time of death Month Day Year To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Tes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ဂ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence After this 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 Pending 2 No Accident Investigation within 24 hours after deal To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number ٥ 29d. Date signed (Month, Day, Year) D68104 9/2/2009 21204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 4105 701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State BALLAND Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician September TNITHONY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 29 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral**)^{Year)}949 Maryland 212-52-4425 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and the memory or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Maryland Anne Arundel Glen Burnie Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 875 South Shore Drive 21060 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Xes 2 ☐ No 14. Race - American Indian. 1 ⊠ Maes 2 □ No If Yes, Give Year or Dates: 67-68 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Transit 12 Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pilli Virginia Shoebrook Anthony ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau 875 South Shore Dr. Glen Burnie MD 21060 Marsha J Pilli spouse 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Md. Veterans Cemetery 9/11/09 Crownsville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home P.A. 3111 Mountain Road Pasadena MD 21122 23a. Part İ. Enter the Asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair re. List only one cause on each line. Immediate Cause (Final **Physician** Atteroscientic (ardiovascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Hypertension Box 68760, Kn Due to (or as a consequence of) Physician/Medical aldemia 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 ☐ Other (specify) signed by the P.0. 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending ours after death. neral Director: Af 1 □Yes 2 □No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

years

42605

Y-CKYS

Day

2 🗆 No

ears

Year

1 ☐ Yes 2 ☐ No

3 AM

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

B

10 NONTH

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DUOSUSUU

BAZTMORE MARYLAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Ruth M. Papino 4 2009 12:51A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore **Examiner** 4c. County of Death N/A6025 Alta Avenue 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months Days Hours Min. (Month, Day, 2-6-1 214-30-6633 Director FL033 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore tXXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 USA 6025 Alta Avenue rould be filed within 72 hours after death and Mental Hygiene.

marked other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Never Married 2 Married ģ Yes 2X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th grade N/A Disabled Disabled Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George M. Papino Gertrude Small 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Cordova-daughter 6025 Alta Avenue Balto, MD 21206 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place King Memorial Pk 9-12-2009 4 Donation 5 Other (Specify) Randallstown, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East wa llOl e. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) month WEASHAND Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Dav Year 1 Yes 2 /2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has performed? Yes 2 No death? 1 🗌 Yes 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital ျ 1 Tes 2 X No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA after death. Director: After this 4 ☐ Nursing Home 5 ☐ Residence 6 ★ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending (Month, Day, Year) Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my orbiton death occurred at the disconnection. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ai d title of certifier 29d. Date signed (Month, Day, Year) okinber 4 2009

State Registrar N.

Charles

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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6701

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SFP 1 0 2009

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31. Date filed (Month, Bay, Year,

Amend#3, perME, G896, 10/15/09, TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Ronald Wayne Parker, Jr. 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day September 6, 2009 6:08 pm **Medical Examiner** anne 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Westbound Route 100 at Snowden River Parkway Columbia 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Min Months Days Hours Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Mitchellville Yes 2 No 28a-f show or other traumatic event, the Medical Examiner must be notified at once. permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number ISA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status Was Decedent Ever in U.S. Armed Forces Never Married Married No Yes Widowed Divorced If Yes, Give Year Yes 2 No Specify: If item 27 is marked other than "natural", ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 grade 17, Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surnam æ 0 (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print a 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 2 Cremation Burial 3 Removal from State mportant: Donation 5 Other Specify 22. Name and Address of Facility Jaugho 21. Signature of Funeral Service Licenses Road Randallston MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Head Injuries Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical UNPENDED AMENDED icate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has death? performed? Yes 2 1 1 Yes No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. funeral director, 25. Was case referred to medica Be examiner? Hospital: 1 Other, Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 ER/Outpatient 3 1 V Yes No 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work Certification: Sep 6, 2009 Driver motorcycle struck guardrail 1757 hrs Natural Pending Yes 2 ✔ No To the Funeral Director: completely filled in by the 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) Route 100 at Snowden River Parkway, Columbia, MD determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and September 7, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) **State**

DHMH 17 Rev 1/2001 OCME 2006 .

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yashodhara Vithal Patel MQ September 8, 2009 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Montgomery Silver Spring 12705 Summerwood Drive If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 € F 200-38-6391 71 India <u>7/16/1938</u> Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Silver Spring MD Montgomery 1X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20904 12705 Summerwood Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Asian Indian 1 □Yes 2 XNo Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) **5+** Healthcare Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Moreshwar Dhopishwarkar Pratibha Dhopeshwarkar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4514 Clearbrook Lane, Kensington, MD 20895 19a. Informant's Name/Relationship (Type. Print) Sanjay Patel Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Ardent Crematory 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/9/2009 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Maryland Cremation Services 21. Signature of Funeral Service Licensee Dorota Marshall Moushall PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death diata Causa (Final

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens Important: if item 27 is marked other the any injury or other traumatic event, the 1 page.

Physician

/Medical

Examiner

10a, State

Director

Funeral

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Completed

Be

Funeral

Director

?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

the Maryland

death with

72 hours after

Baltimore, Maryland 21215-0036

siclan and burial-trans attending physician for use as the buria signed by the a page 2 s director, 124 hours after dea h.

le Funeral Director A
bletely filled n by the fu

certificate

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within 24 hour To the Fune completely fi

Hospital or Attending

Medical

29b. Signati

Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

	disease or condition	Metastatic Colon Cancer	6 years
	resulting in death)	Due to (or as a consequence of):	
	Conventielly list conditions	h -	
ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	Due to (or as a consequence of):	
Œ.	Cause (Disease or injury that initiated events	c.	
EX	resulting in death) Last	Due to (or as a consequence of):	•
cal		d	
Completed by Physician/Medical Examiner			
≥	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	23d. Date of delivery
icia	in the past 12 months? 1 ☐ Yes 2 ☑No	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year
Jys	9 Unknown	9 ☐ Unknown	
Y P	Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
q p		1 🗆	Yes 2X No 3 Probably 4 Unknown
ete		a. W.	Odb. Mars automa findings audibble
둳		24a. Was	
S			2 No 1 Yes 2 No
Be	25. Was case referred to medical examiner?	26. Place of Death (Check only	one)
္	1 163 2 M 140	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🛣 Res	idence 6 ☐ Other (Specify)
Ë	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe (Month, Day, Year) Injury 28b. Time of Work?	how injury occurred
ati	2 ☐ Accident investigation	M 1 □Yes 2 □No	
tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location City or To	(Street and Number or Rural Route Number, wn, State)
dical Certification: To		Dity of 10	m, sate)
al	29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, death occurred at the time, date and place, and due to the	e cause(s) and manner as stated.
ğ	(Check only 2 Medical Exam	iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.	, date and place, and due to the cause(s)

State Registrar

31. Date filed (Month, Day, Year) SEP 1 0 2009

6420 Rockledge Drive, Suite 4100, Bethesda, MD Ralph V. Boccia, M.D. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 29675

29d. Date signed (Month, Day, Year)

September 9,2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	Amena #2	State of N	Maryland		artment of h			ental Hy	giene Reg. No.		^	22000
			Registrar 1. Decedent's Name	e (First, Middle, Las	:t)				<i></i>		2. Date of De	eath			Time of Death
	Physici		Moeri	ta	Не	len	Ros	ssman			Month SODIS	mbo		oco i	1:00 PM
-	/Medic Examir			f not institution, give			1101	4b. City, Town, o	r Location	of Death	001-10	1	County of De		
	Lamin		7 Beacon	Hill Roa	ad			Baltimor	ce.			Ва	ltimor	ce	
	Funeral		5. Social Security N			Age (In yrs. la	ast birthday)	if Under 1 Year Months Days		24 Hrs. 8	8. Date of Bi (Month, D	rth	9. E		(State or Foreign
	Director		212-84-1	.426	□M 2XDXF	93	Yrs.	Months Days	Houis	IVIIII.	Augus	t 14	1916		ralia
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Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, if a Modical Example and the rediffical at once.	by Funeral	11. Marital Status1 ☐ Never Marr3 ☐ Widowed	ied 2□ Married 4□ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	s? X No		Was Decedent of H f Yes, specify Cub I □Yes 2 ☑ No	an, Mexica	n, Puerto R	lican, etc.)	0-	Black, WI	hite, etc.	olali,
9-0	2 ho	Completed	/Cna	15. Decedent's Ed	ucation		16a. Dece	dent's Usual Occup	pation	nt of working	~	16b. Ki	nd of Busines	ss/Industr	<i>-</i>
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Ĕ	Pag ment ant:			5 Other (Specify		Met	ro Cre	matory I	nc. 9	/10/2	009	Balt	imore	MD	
Baltimore,	epart epart port y inj		21. Signature of Fo	meral Service Liden	see		22	. Name and Addre	ess of Facil	ity Sta	llings	Fun	eral H	ome 1	P.A.
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			23a. Part 1. Enter t shock, or hea	h disease, or on plant art liture. List only	olications that caus one cause on each	ed the death line.	. Do not ent	er the mode of dyi	ng, such as	s cardiac or	respiratory	arrest,		App	roximate rval Between
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	/Medical		resulting in death)			as a consequ		VG VISSTORY							
	Examiner	ایا	Sequentially list co	nditions.	b										
0	ed sit	dical Examiner	Sequentially list concause. Enter Under Cause (Disease or	erlying	Due to (or a	as a conse ju	ence of								
131	cate be executed physician and the burial-transit	cam	that initiated events resulting in death)	5	C		of):								
50,	be ex	Ē	and accounty		Due to (or a	as a consequ	ierice oi):								
8760,	cate l physic the b	dica	d											-	
Box 6	or Attending Physician: The law requires that the death certific that death. Differd cath. Differctor: After this certificate has been signed by the attending p in by the funeral director, page 2 should be detached for use as:	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy								23d. Date of			delivery	
B.	deal	icis	in the past 12 1 ☐ Yes 2	months?	4 ☐ Pregnan	t at time of de	eath 5	Other (specify)					Month	Day	Year
P.O.	law requires that the di as been signed by the 2 should be detached	hys	9 Unknown		3 - Olikilowi										
ď,	gned gned se de	oy F	Part II. Other signi	ficant conditions o	ontributing to death	but not resu	Ilting in the u	nderlying cause giv	ven in Part	I.	23e. Did	tobacco ı	use contribute	e to the ca	use of death?
2	en si uld b	ed	Chronic	OPZYVC	rue full	nonan	y DD	6456_			1 🗆	Yes 2	□No 3□	Probably	4 🕅 Unknown
သို့	aw re as be 2 sho	Completed by	12moluse	me							24a. Was		24b. Were	autopsy f	indings available tion of cause of
ď	The law ite has age 2 s	E O	Compost	on the A	Failure						auto perf 1 □ Yes	ormed? 2 X No	death	to comple 1? ∕es 2□	
ita	ician: The certificate ector, pag	Be C	25. Was case refer	red to medical	Talloic				26. Plac	e of Death	(Check only	one)	,		_
>	Physic this ce al direc		examiner? 1 ☐ Yes 2 🗖	No	Hospital: 1 ☐ Inpa	atient 2 🗆 I	ER/Outpatier	nt 3 DOA Oth	her: 4 🗆 N	lursing Hom	ne 5 🖟 Rec	idence	6 Dau 6 Dther (S	ghter Specify)Re	sidence
0	ding Ph n. After th funeral		27. Manner of Deat		28a. Date of Ir (Month, I	njury Day Year)	28b. Time o	28c. Inju Wo	ry at	28	8d. Describe				
<u>.</u>	arh. r: Af	atic	1 Natural 2 Accident	5 Pending investigation		- u,, , c u.,	,,]Yes 2□]No					
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 Hours after death. To the Funeral Director: After this certificate h. completely filled in by the funeral director, page	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of I building,	njury - At ho etc. (Specify	me, farm, str	eet, factory, office		28	8f. Location City or To	(Street an wn, State	nd Number or	Rural Ro	ute Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	2	29a. Certifier	1 Certifying Ph	ysician: To the be	st of my knov	wledge, deat	h occurred at the t	ime, date a	and place, a	and due to th	e cause(s) and manne	r as stated	d.
	ie Hos 124 h ie Fur jetely	Medical	(Check only one)	2 Medical Exam	niner: On the basis and manner	of examinat stated.	tion and/or in	vestigation, in my	opinion, de	ath occurre	d at the time	, date and	d place, and	due to the	cause(s)
	To th To th Comp	Me	29b. Signature and	title of certifier				29c. Licen:	se number			29d. Da	te signed (Mo	onth, Day,	Year)
			DA OILA	ah HSU	rtin			H450	131			Sép	Hombo	N 810	1 2009
V	6		30. Name and add	ress of person who	completed cause o	f death (Item	23a) (Type,	1		1			0		
			Deba	Jah Bur	ton 54	01 06	DCOM	ET ROTH.) R	anda	llston	ni	W Z)	
	Sta	te	31. Date filed (Mor	th, Day, Year)	32. Regis	strar's Signat	ture								
	Registr	ar		SEP 1 0 20	09		1 6	and I							
DHN	MH 17 Rev 1/2	001			2.51	- /	19	Y GY WOR							

ORIGINAL.

Please Type or Print in Black Indelible Ink. Finsure All Copies Are Legible.
Amend 20b-c, per File 6895 9/10/109. TI
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day Year Month **Physician** seborough 2009 1130 09 05 /Medical 4a. Facility Name If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Kaltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕱 F Yrs Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examinal must be mutified at Baltimore 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number WINSTON Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 21215-0036 Specify 1 ☐ Yes 2 X No Black Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Magnes. Elementary/Secondary (0-12) College (1-4or 5+) State of Mary Maryland 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be Koseburovah ပ္ U 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daughter Baltimore, 9/15/2009 20c. Location - Oity or Jown, State Owings Mills, MD 20a. Method of Disposition Place of Disposition (Name of Carry Lson Py Foreste) 1 Burial 2 ☐ Cremation 3 Removal from State 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Greene laryland 21212 Baltimore, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner ENDOCARDITIS INFECTIVE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for as a consequence off the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ FAILURE 2 ☐ No 3 ☐ Probably 4 ☐ Unknown STAGE RENAL 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 After this certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: completely filled in by the 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES OUD SEPTEMBER 5, 2009 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21239 KUMAR 5601 LOCH RAVEN BLVD 31. Date filed (Month, Day, 32/Registrar's Signature Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Sept. **Physician** 6, 11:30pM Ronald G. Rice /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Middle River 139 Lariat Road Months Days Hours Min. April 1947, 149 36 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 219-32-6137 1 M 2 □ F 72 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evantmer must be notified at any injury or other traumatic event, I'm Medical Evantmer must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Baltimore Middle River MD 1 Yes XXNo Director 10f. Zip Code 21220 10e. Street and Number 139 Lariat Road 10g. Citizen of What Country? USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status XXes 2 No If Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No <u>م</u> 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) A&P Warehouse Packer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Robinson Gleason Rice ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 139 Lariat Rd. Middle River, MD 21220 19a. Informant's Name/Relationship (Type. Print) Penny Rice/ Wife 20b. Place of Disposition (Name of Garden Semator of The flatch 20c. Location - City or Town, State Rosdale, MD 20a. Method of Disposition 09/1^{Date}/09 XXBurial Cremation 3 - Removal from State 5 Other (Specify) Signature of Juneral Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Essex Balto 21221 Path. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sophageal 400 /Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit Box 68760, Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of cortiller. 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

and address

31. Date filed (Month, Day, Year)

STUTES

SEP 1 0 2009

MICHAEL

Parkville

of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatu

HARFORD

-06876 thur Deroalde:	s Pa	Please Type or Print in Black Indelik manjon State of Maryland / Departme			ible.			
			te of Death		g. No. 2000	ime of Death		
Physicia edical Exami		Arthur deRoaldes Remanjon, Jr.			Day Year 2, 2009	2136 hrs		
		4a. Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Location of Baltimore	Death	4c. County of Death			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day) If Under 1 Year If Under Months Days Hours	Min	h(MM/DD/YYYY) 9. Birthpla Foreign			
Director		215-68-1666 1XM 2 F 54 Usual Residence of Decedent	Yrs.	Feb. 3	, 1955 Country	// Maryland		
w any		10a. State 10b. County 10c. City, Town o			1	I. Inside City Limits X Yes 2 No		
aryland 8a-f sho at once.	Director	Maryland Baltimo	10f. Zip Code	10	g. Citizen of What Country?			
72 hours after death with the Maryland n"matural", or items 23a or 28a-f show any al Examiner must be notified at once.		2409 Pelham Ave.	21213	τ	United State	ited States		
r death with or items 2	Funeral	11. Marital Status 1 Never Married 2 Married 2 Armed Forces?	 Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican, 		14. Race - American White, etc.	Indian, Black,		
after de al", or	by Fu	3 X Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: White			
2 hours "natur Exam	eted I		ecedent's Usual Occupation (Give k uring most of working life, DO NOT u		16b. Kind of Business/Indu	stry		
0036 within 7 iene. er than	Completed		otographer		Photography			
21215-0036 Muld be filed within 72 hours after filed within 72 hours after marked other than "natural", to event, the Medical Examiner.	Be Co	17. Father's Name (First, Middle, Last) Arthur deRoalles Remanjon, Sr.		s Name (First, Middle, M Se Semple	iaiden Surriame)			
, MD 21215-0036 and 2 should be filed within ealth and Mental Hygiene. Item 27 is marked other that traumatic event, the Medic	To		Mailing Address (Street and Numl					
nore, MD 2 ages I and 2 shou nt of Health and N tt: If item 27 is n other traumatic		20a. Method of Disposition 20b. Place of	Allen Street, L Disposition (Name of cemetery, ry or other place)	Date	20c. Location - City or Tow	vn, State		
Baltimore, permit. Pages I an Department of Her Important: If ite		1 Burial 2 X Cremation 3 Removal from State Evans 4 Donation 5 Other Specify:	Funeral Chapel	09/09/2009	Forest Hill	•		
Baltimo permit. Page Department of Important: injury or ott		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Evans Funeral C	hapel & Cren	mation Servi	ces -BelAi		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	12 MCMPOTE DITA	TOTESC IIII	est, shock, or heart A	Approximate Interval Between Onset and		
/Medical caminer		Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):				Death		
	<u>_</u>	Sequentially list conditions, b						
00	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated						
xecuted and ransit	cal Exa	d						
न्न ज ७	edica	UNPENDED AMENDED	23d. Date of delivery					
ox 68760, eath certificate be ex- attending physician for use as the burial	ian/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2		pregnancy	Month Day	Year		
Box 68760, e death certificate be the attending physic ed for use as the but	Physician/Medi	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	Other (Specify)					
Records, P.O. Box 68760, The law requires that the death certificate be are has been signed by the attending physici age 2 should be detached for use as the buri	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Pa		obacco use contribute to the 2 V No 3 Probabl			
cords, law require has been si	Completed			24a. Was a		sy findings available pletion of cause of		
Reco The lavicate has	Somp			perfor 1 ✓ Yes	rmed? death? 2 No 1 Yes	2 No		
Vital Re hysician: The this certificate I director, page	o Be (25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Ou	26.Place of Death (tpatient 3 DOA Other4		Residence 6 Other:			
Division of Vital Records, rate above required to Attending Physician: The law required to the control of the process of the process of the forest of the funeral director, page 2 should be an by the funeral director, page 2 should be a second to the funeral director.	⊢ ⊢	27. Manner of Death 28a. Date of Injury 28b. T	ime of Injury 28c. Injury at Work	? 28d. Describe	how injury occurred otorcycle struck by ve	hicle		
ivisior or Attend after death Director:	icatic	2 Accident Investigation 28e. Place of Injury - At home, fail	m, street, factory, office building, etc		Street and Number or Rural	Route Number, City		
Divious after uneral Dir	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street			rkwáy at 39th Street, Bal	timore, MD		
To the Hospital within 24 hours To the Funeral	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal one) Wedical Examiner:On the basis of examination and/or in	th occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the caus curred at the time, date	se(s) and manner as stated. and place, and due to the c	ause(s)		
To To	Me	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month,			
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E.		September 3, 2009	· · · · · · · · · · · · · · · · · · ·		
10			111 Penn Street, Baltimore	e, MD 21201				
S Regis	tate trar	31. Date filed (Mon SEP Year) 0 2009 32. Figurar's Signature	Have Baltimore					

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 5, 2009 Robert Ellis Robinson September 9:01 p. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Montgomery Suburban Hospital Bethesda 8 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Min. 1 M 2 □ F Months Days Hours 89 Feb. 7, 1920 Texas 704-01-6457 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 20904 United States 3122 Gracefield Rd. #T20 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Affiled Folces? 1★JYes 2 □ No IfYes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2√2 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Journalist / Publisher 12 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Neva Florence Robinson Guffie Jefferson Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Nell Boone Robinson-wife 3122 Gracefield Rd. #T20 Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Beltsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 9, 2009 22. Name and Address of Facility Rapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Ischemic Cardiomyopathy disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

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Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exeminating the notified at agine.

Maryland 21215-0036

Baltimore,

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Examine Physician/Medical

physician and s the burial-trans use as attending the detached à cate has been signed page 2 should be det certificate this After thi funeral

þ Completed

Be

Certification: To

Medical

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

2 No

9 Unknown

failure

1 ☐ Yes

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

one)

4 Homicide

1 X Natural

Vital Division of the Hospital or Attending I hin 24 hours after death.

executed be Box Records,

ROBINSON

completely

State Registrar 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe aortic stenosis, pneumonia, acute renal

9 D Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

September 6, 2009

24a. Was an autopsy performed? 1 Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Other: 4 Nursing Home 5 Residence 6 Other (Specify) t Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

🏝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0060115

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert

MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Rd. Bethesda, MD 20814 M.D. Park, J.

32. Reg 31. Date filed (Month, Day, Year)

Amend #30 per DVR 8895 9 10/09 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 5, 2009 Year 12:45 AM **Physician** Thomas G. Rossbottom /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A Baltimore Harford Gardens If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Unknown 5. Social Security Number 6. Sex **Funeral** December 18, 1937 Months Days 1 XM 2 □ F Hours 121-28-4846 71 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at Baltimore 1X Yes 2 □ No N/A Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Wedlest Evantmer must be monee. USA 10 North Calvert Street Suite 200 21202 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 □Yes 2 No Specify Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Sollege (1-4or 5+) Tools Salesman 18. Mother's Name (First, Middle, Maiden Surname) Unknown 17. Father's Name (First, Middle, Last) Unknown Be ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 N. Calvert Street Suite 200 Baltimore Maryland 21202 Terry K. Sullivan/ Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/8/09 Towson Maryland Hilltop Service Corp. Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final rerebrovanillas **Physician** accid disease or condition resulting in death) /Medical Examiner Condivioncular disease. Atherosclewhic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jigar I. Shah, MD 8813 Waltham Woods Rd. Suite 204 Parkville, MD 21234 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Please Type of Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Luise Maria Rathell 2009 September 1:15 9 Α. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Severn 1569 Redhaven Drive 8. Date of Birti05/04/1932. Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 🕱 F 218 82 1335 77 W. Germany 09/09/2009 Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 1 ☐ Yes 2 X No Anne Arundel Severn Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1569 Redhaven Drive 21144 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ∐Yes 2 🕱 No Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martin Friedrich Wilhelm Kirstein Margaretha Kunigunda Panzer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Rathell / Husband 1569 Redhaven Drive Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 09/12/2009 Baltimore, Maryland Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 grameroush 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AMYOTROPHIC CATERAC SCLERDOUS disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 🗸 Yo 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 □Yes 2 □No

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Examiner Physician/Medical þ Completed Be Certification: To funeral filled in by the

Physician

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10a. State

Funeral

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Department of Heall Important: If item 2 any injury or other

Physician

/Medical

Examiner

72 hours after

Maryland 21215-0036

Baltimore,

Director

Funeral

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Completed

traumatic event, the Medical Examiner must be notified

25. Was case referred to medical

27. Manner of Death 1 Natural 2 Accident investigation 6 Could not be 3 ☐ Suicide determined

4 Homicide 29a. Certifier (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SURVA MUNDAY MD 8021 RITCHE HUY PASADENA RIPS

1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

ND

29c. License number D21776

29d. Date signed (Month, Day, Year) SEPTEMBER 9 2009

State Registrar

Medical

31. Date filed (Month, Day, Year)

within 24 hours a

To the Funeral I

completely filled To the Hospital

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ı	Physicia		1. Decedent's Name (First, Middle, Last) Neva Russell			-		2. Date of Dea Month Sentembe		/ear	3. Time of Death 6:40 A M	
-	/Medic Examin		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, o	r Location of Death	о респи				
<u>/</u>			204 Ammunition Avenue	17 A - (t	- 1 1	Odento		8. Date of Birth	Anne A		1 ce (State or Foreign	
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	(e V		30. Name and address of person who completed of RICHAND EHSH	ER		PAIN TOU	NERS	GLEN	V BUR	NIE	MD	
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Physician
/Medical
Examiner

Funeral Director

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State

1 - State Registrar	Cer	tificate of I	Death		Reg	g. No.		- 100 pp - 10 m2 - 10			
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4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death 4c. County									
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	(In yrs. last birthday)	If Under 1 Year	O. Disther	lace (State or Foreign							
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Usual Residence of Decedent											
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MD BALTIMORE		1 □ Yes 2X No									
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17. Father's Name (First, Middle, Last)	ITTENDEDO				st, ivilaale, ivi	aiden Surnan					
BENJAMIN E R	UTTENBERG	:	CL/			CHEPC					
19a. Informant's Name/Relationship (Type. Print)		g Address (Street				-		Code)			
ELLEN CAMPANA / DAUGHTER	1 SAF	RATOGA CO	OURT, I	PISCAT			3854				
20a. Method of Disposition	20b. Place of Dispos cemetery, crem	atory or other plac	e)	Date		0c. Location -	City or To	wn, State			
1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	OHEB SHA	LOM	09	9/09/2	009	REIST	ERST(OWN, MD			
21. Signature of Funeral Service Licensee	22	Name and Addre	ss of Facility	S01 1	FVINS	ON & B	ROS.	TNC			
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that initiated events c.	a consequence of):						-				
Due to (of as	a consequence oi).										
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IF FEMALE:											
23b. Was decedent pregnant 23c. If yes, outcome		Ectopic pregnanc	v				ite of delive onth	ery Day Year			
1 Yes 2 No 4 Pregnant a		Other (specify) _				IVI	JIIIII	Day Teal			
9 🗆 Unknown											
Part II. Other significant conditions contributing to death be			en in Part I.					he cause of death?			
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25. Was case referred to medical			26 Place	of Death (C	1 □ Yes 2 heck only one		1 🗆 Yes	Z 🗆 (NO			
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one) and manner sta	ned.	29c. Licens	e number		00	9d. Date signe	ed (Month	Day Year)			
29b. Signature and title of certifier				r2	28	So plems	ber	7, 2009			
Maladul			0546			7710101		- 5 2007			
30. Name and address of person who completed cause of de Holly R Dahlman, MD; 23	eath (Item 23a) (Type, I	Print)	Suite-	210. 1	119/2-	-111-	K-17	01000			
Holly K Dahlman, MD; 2	60 W Jappa	a Koad-	surt.	~10) L	u irecy	vive,	716	21043			
31. Date filed (Month, Day, Year) 32. Figistr	ars Signature	a del									
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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 Month **Physician** August 5:00 PM 31 TON /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Haywara altimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Sex 1☐ M 2☐ F Days Hours Months 920-50-153 Raltimore, MI 6 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Modical Evanings must be notified at 1 NYes 2 No Funeral Director more 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 Havwaro USF 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify ac Completed by Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maiden Surname) 18. Mother's Name (First, Middle. 17. Father's Name (First, Middle Be ٩ 19a. Informant's Name/Belationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mi HIMOLE permit. Pages 1 and Department of Healt Important: If item 2: any injury or other: once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility naras torke 2120 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** arrhthymia mmediate Cardrac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sleep apple

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 Tyes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate | 1 □Yes 2 No 1 ☐ Yes 2 No pertension 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🕻 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 Yes within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Medical 29a. Certifier 🛮 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 10035363 0 person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Marshallmo

31. Date filed (Month, Day, Year)

(0

Registrar's Signature

32.

09-06883

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009-	2889	İ
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Caroline Maxine S		more - For State	Sta	ite of Maryla	and / Depa	artment of rtificate of	Health and	Menta	I Hygiene			2000	1-2884
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Physicia Medical Examin				xine Si	zemore	<u> </u>			Monti Sept	ember 3			0622 hrs
(4a. Facility Name (if n	ot institution			4	b. City, Town, or L Westminster		Death		4c. County of Carroll	Death	
	4	10 Washingto		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2	24Hrs. 8. Dat	e of Birth (MM/DD/YYYY)	9. Birthpl	ace (State or Foreign
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Maryli 28a-f	Director	10e. Street and Numb		on Rd.	Ant 6	;	10f. Zip Code 2115	:7		109.	USA	at Country	
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ours a	g p	15. Decedent's Edu		cify only highest gra		16a. Deceden	nt's Usual Occupatiost of working life.	on (Give kir DO NOT us	nd of work dor se retired)	ne 1	6b. Kind of Bu	siness/Indi	ustry
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		Nichelle		s-daugh			Wilder sition (Name of cer		Dr . Date		20c. Location -		
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Box 68760, e death certificate be the attending physic ed for use as the bur	ian/Me	IF FEMALE: 23b. Was decedent p	pregnant in t		s, outcome of pr		iotal death 3	Ectopic	pregnancy		23d. Date of Month	of delivery Da	ay Year
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P.O.	by P	Part II. Other signif	ficant condi	tions contributing	to death but no	ot resulting in the	underlying cause	given in Pa	II(I.	1 Yes			abiy 4 🗸 Unknown
lS, F quires en sigr										24a. Was a		Were aut	opsy findings available
OFC law rehas be 2 short	Completed						-		— <u> </u>	autops perform	med?	death?	ompletion of cause of
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Division of Vital Records, spital or Attending Physician: The law requirmoral Director: After this certificate has been siy filled in by the funeral director, page 2 should by filled in by the funeral director, page 2 should be seen of the control of the contro	Certification:	3 Suicide	6 Co	uld not be 28e. P		At home, farm, sti	reet, factory, office	building, et	tc. 281.	or Town, S	tate)	Del Ol ING	iai Rodio Hambori, and
Division of Vital Hospital or Attending Physician: 24 hours after death: Funeral Director: After this certif tely filled in by the funeral director,		4 Homicide 29a. Certifier	0 00 00	Thursday To the	hoot of my know	ledge death occ	curred at the time.	date and pla	ace, and due t	to the caus	e(s) and mann	er as state	ed.
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. The I To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Medical	(Check only one) 2	Medical Ex	aminer: On the bas	sis of examination	on and/or investig	gation, in my opinio	on, death oc	ccurred at the	time, date	and place, and	I due to the	e cause(s)
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		30. Name and addr					11 Penn Stree	t Raltim	ore MD 21	1201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4c. County of Death Name (If not institution, give street and number) Town, or Location of Death Ma Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) 1 ☐ M 2 🔀 F Months Davs 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No timore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ephone (Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Noute Number, City or Town, 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural 20a. Method of Disposition Burial 2 Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Lel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of tying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLON CANCER disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2**X** No 1 🗆 Yes 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical **Examiner** Examine The law requires that the death certificate be executed

Physician /Medical

Examiner

Funeral

Director

28a-f show

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is marked other than

Important: If Item 27 any injury or other tr

Director

Funeral

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Completed

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injury or other traumatic event, the recital Examiner must be notified at

death with the Maryland

be filed within 72 hours after

Maryland

Baltimore, | SEPTEMBER

Box 68760

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Division of Vital

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within 24 hours a

To the Funeral C Hospital

Physician/Medical

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Certification: To

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29a. Certifier

IF FEMALE:	
23b. Was decedent pregnar in the past 12 months?	
1 □Yes 2 🗶 No	
9 🗌 Unknown	

Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE

28d. Describe how injury occurred

Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1X Natural 5 Pending 2 Accident investigation 6 Could not be determined 3 🗌 Suicide

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the curse Practitioner stated. iminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) X Nurse 29b. Signature and title of ertif

29c. License number

29d. Date signed (Month, Day, Year) ٥

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIAM BAKIR, CRNP 31. Date filed (Month, Day, Year)

SEP 1 0 2009

2300 DULANEY VALLEY RD.

32. Registrar's Signature

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Ye ar 2009 **Physician** Street George 8, 5:00 PM September /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death Examiner Harford Co. Forest Hill Forest Hill Nursing Home 8. Date of Birth (Month, Day, Year) Tan. 20, 1931 5. Social Security Number If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex Funeral Months Days Hours 1 X M 2 □ F 78 215-28-0244 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c City Town or Location 10a State 28a-f show traumatic event, the Medical Exercitor is ust be notified at 1 TYes 2 TANO Director Edgemere Baltimore MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö death with 21219 United States 7716 North Point Creek Road 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items ? 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 XNo Specify: 2 Specify: 3 Widowed 4 Divorced White 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 Il Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien, important: If item 27 is marked other the any Injury or other traumatic event. Steel Industry Steelworker 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Baum George M. Street ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 33042 1067 Loggerhead Lane Sugarloaf Key, FL Deborah Street (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 9/10/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Duda-Ruck Funeral Home of Dundalk, 21222 Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or shock, or heart failure. List implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End stay Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 9 I Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? 1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate h completely filled in by the funeral director, page Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 200 133227 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. MacPha 6,5 DU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 1 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 8:05P Schluderpe Ci 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Baltimore Charlestown Care Center Catonsville Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Min. Hours 1 ☐ M 2 🂢 F Months Days 80 MD Director 220-20-2983 03-16-1929 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Nexical Exemination and injury or other traumatic event, it a Nexical Exemination. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Baltimore Catonsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 216 S. Rennaisance Gardens 21228 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: \$ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounting 12 Chemical Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew Panasuk ပ Anna Bobenko 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11869 Grand Isles Lane Fort Myers, FL Mrs. Donna L. Cayer/ Daughter 33913 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Glen Haven Mem. Park: 09-11-2009 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD 21. Signature of Funeral Service Licensee oraled mx Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician rereinom /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Undership Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐No detached 9 ☐ Unknown 9 ☐ Unknown neral urrector: Atter this certificate has been signed rilled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> ular 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No perten 24a Was an autopsy performed? Yes 2 No 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩6 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours the Funeral 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Dou

Deneen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

7-11

32. Registrar's Signature

Maiden

29c. License number

choice Lane, Cytons ville

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	-	State Registrar			Cer	rtificate of	Death			Reg. No.	2010	20	89	
		1. Decedent's Name (First, Middle, L	ast)					2.	Date of De Month	ath Day	Year	3. Time of	Death	
Physician /Medica		Ellena K.	Simmons	S					09	07	2009	9:31	РМ	
Examine		4a. Facility Name (If not institution, g		·		4b. City, Town, o	r Location of	Death		4c. (County of Death			
		6803 Clinton M	anor Drive			Clinto	n			p.	rince G	2017066		
neral			Sex 7. Age ((In yrs. last bir	thday)	If Under 1 Year	If Under 2 Hours		Date of Bir (Month, Da	th	9. Birth	place (State ontry)	or Foreign	
ctor		241-32-7661	1 □ M 2 🔀 F	88	Yrs.	Months Days	Hours	Min. 1	1/12/		000	NC		
		Usual Residence of Decedent												
		10a. State 10b. County	1	0c. City, Tow	n or Lo	cation						10d. Inside Ci		
	9	MD Prince	George's	Clinto	n							1X Yes	2 □ No	
	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Cou	ntry?		
		6803 Clinton M	anor Dr.			20735				USA				
	runerai	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. V	Was Decedent of H	lispanic Orig	in? (Specif	y Yes or No)- 1	4. Race - Amer			
		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			1 □Yes 2 ☑ No	Specify:	r derio mic	an, cro.)		Black, White,			
	5	3 X Widowed 4 ☐ Divorced	Ye ar or Dates:		"	I I les Zigino	оресну.				Specify: Bla	ck		
	Completed	15. Decedent's l	Education	16a	. Deced	dent's Usual Occup kind of work done	oation	of working			d of Business/Ir			
	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)		life. L	DO NOT use retired	d)	or working						
I	5	8th		Ho	Homemaker					Hou	sekeepi	ng		
	a a	17. Father's Name (First, Middle, Las	it)				18. Mother	r's Name (F	irst, Middle	, Maiden S	Surname)			
	2	John L. King					E11a	a Mae	Pope					
ľ		19a. Informant's Name/Relationship	(Type. Print)	19b	. Mailin	ng Address (Street	and Number	r or Rural F	Route Numb	er, City or	Town, State, Zi	p Code)		
		Michelle D. Simm	ons/Daughter	68	303	Clinton :	Manor	Dr. (Clinto	n MD	20735			
once.		20a. Method of Disposition		20b. Place o	f Dispo	sition (Name of natory or other plac	ce)	Date	9	20c. Loc	cation - City or T	own, State		
ı		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec			-	1emorial	i i	9/14	/2009	Lan	dover M	D		
	ŀ	21. Signature of Funeral Service Lice		narmo.		2. Name and Addre								
		1 Dimarelia	ll 1409	77		4217 9th								
ľ	1	23a. Pari 1. En er the disease, or co	mplications that caused th		not ente							Approximat		
ı	- 1	show, or heart failure. List onl Immediate Cause (Final										Interval Bet Onset and I		
ı		disease or condition resulting in death)	a. Alzhe	eimer':	_						-			
1	- 1		Due to (or as a c	consequence	oi).									
	- E	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence	of):									
	B۱	cause. Enter Underlying Cause (Disease or injury			·									
	Схашпе	that initiated events resulting in death) Last	c Due to (or as a c	consequence	of):									
			N. al											
1	/Mealcal		_ d											
1	\$	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnancy						2	3d. Date of deliv	/erv		
		in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti			☐ Ectopic pregnand ☐ Other (specify) _	су			- 1	Month		Year	
	rnysicia	1 □ Yes 2 XXI o 9 □ Unknown	9 ☐ Unknown			_								
		Part II. Other significant conditions	contributing to death but	not resulting i	n the ur	nderlying cause giv	en in Part I.		23e. Did tobacco use contribute to the cause of death?					
	a Dy	Seizure Disord	er						1 🗆	Yes 2	No 3□ Pro	bably 4 🗌	Unknown	
1	Completed								04= 14/==		0.4h 14/ava ava	anau findings	auailahla	
	-							—	24a. Was		24b. Were aut prior to co death?	opsy inumes ompletion of c	available ause of	
3	3								1 ☐ Yes		1 ☐ Yes	2 % T No		
å	מ	25. Was case referred to medical examiner?	Hospital			- 104			Check only					
	2	1 ☐ Yes 2 ☐XNo	Hospital: 1 ☐ Inpatient				4 🗆 Nui				☐ Other (Spec	ify)		
	Cerunicanon.	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day,)	Year) 28b.	Time of Injury	Wor			d. Describe	how injury	occurred			
13	20	2 ☐ Accident investigati	he distribution				Yes 2 N	10						
		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		r - At home, fa (Specify)	rm, stre	eet, factory, office		28f	 Location (City or To 	Street and wn, State)	f Number or Rui	ral Route Nun	nber,	
18	3		N											
		29a. Certifier 1 ☐ Certifying I	Physician: To the best of aminer: On the basis of e	my knowledg	e, death	h occurred at the ti	ime, date and	d place, and	d due to the	cause(s)	and manner as	stated.	3)	
70	Medical	one)	and manner state			γ								
BA	2	29b. Signature apartle of certifier	0 11			29c. Licens	se number			29d. Date	e signed (Month	, Day, Year)		
		1/an	1 HV	-		5323	15			9/9/	2009			
	1	30. Name and address of person wh	o completed cause of dea	ith (Item 23a)	(Type,									
		Darryl Hill MD	13635 Balt:	imore	Ave.	South L	akes (Office	e Parl	c, La	ure1 MD	20707		
State		31. Date filed (Month, Bay, Year)	32 Ab istrar's	s Signature	223									
istra		SEP 1 A 2	009 Serve	1	BA	who								
. 1 /000	4		100	14	7	(Marie Car								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Day Month **Physician** Stills 2009 5:30pm Charles Sept 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richie Hospice n/a Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs **Funeral** 1 **X**M 2 □ F Months Days Hours 218-36-1361 Director 68 Dec12,1940 Va Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, The Medical Exercitor must be redified at Director 1XYes 2 □ No n/a Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 6205 Marlora Rd 21239 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1
Yes 2
No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 □Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: ş 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Balto.CityHousing Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nellie S. Pride ဥ Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a permit. Pages 1 and. Department of Health Important: If Item 27 any injury or other tr once. Md. 21239 Myrna L. Stills/Daughter 6205 Marlora Rd. Balto. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State GreenmountCrematorySept9.2009Balto,Md 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD 21213 23a. Part 1. Enter the disease, or complications in the used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Circhosis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner artery Coronary Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner burial-transit Due to (or as a consequence of): as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 Physician: The certificate 1 ☐Yes 2 ☐No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗐 🗸 🗸 🗸 🗸 0 Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 □Other (Specify) JR Hospice 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie MD 53275 09-07-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 21287 NGUYEN DONG 600 N. Wol 32. Registrar's Signature 31. Date filed (Month, Day, Year) State SEP 1 0 2009 Registrar

400

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #26, per MD g895 9/10/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year 11:00 PM 2009 DONALD FRANCIS SWEENEY, SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore City 8. Date of Birth (Month, Day, Year) 09/28/1953 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours 1 **2** M 2 □ F Months Davs 55 215-64-3361 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 ☐ Yes 2 ☑ No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 Funeral 584 Upton Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: Completed by Specify: White 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Belle Grove Sand and Gravel College (1-4or 5+) <u>Superintendent</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Hamilton Francis Sweeney Helen Marie Nazarenus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 584 Upton Road, Severn, Donald F. Sweeney, Jr./Son MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) . Method of Disposition Fn tombment
1□ Burial 2□ Cremation 3□ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Pk Cemetery 09/02/09 Baltimore, MD 21. Signature of meral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Euler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ye each line to Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ten minutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 K Inpatient Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature as 29c. License number of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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3. Registrar's Signature

Parkber

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009-28898

		1- For State Registrar	,		Certifica	ate of	Death	_		Reg. No.	000	0000
Physicia	ın/	Decedent's Name (First, Mid	dle,Last)						2. Date of De Month	Day Y	rear	3-Time of Death
edical Exami	ner		D THOMAS		EENEY,	JR.			Septemb	er 4, 2009		1638 hrs
		4a. Facility Name (if not institut 7894 Tall Pines Cou		number)		4t	Glen Burnie	cation of	Death		ty of Death Arundel	
Funeral		5. Social Security Number	6. Sex	7. Age (li	n yrs. last birt	hday)	If Under 1 Year	If Under		Birth (MM/DD/YY	YY) 9. Birth Cour	place (State or Foreign
Director		220-08-6328	1 ✓ M 2 F		39	Yrs.	Months Days	Hours	Min. 11/1	1/1969		yland
any	-	Usual Residence of Decedent 10a. State 10b. Count		110	c. City, Town	or Locatio	n .					10d. Inside City Limits
ınd show aı	ř		ne Aruno		•		Burnie	į				1 ☐ Yes 2 ✔No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number					10f. Zip Code			10g. Citizen of		•
ith the 23a o	al D	7894 Tall Pin		t, Ap		12 18/00		061	n? (Specify Yes or N		U.S.A	an Indian, Black
ath w items	Funeral		Married Armed	Forces?					Puerto Rican, etc.)		hite, etc.	arr indian, black,
Rer de		3 Widowed 4 D	1 Yes		No	1 🗆 🕽	Yes 2 V No	specify:		Specif	r⁄∵ Whi	te
72 hours after n "natural", o	Completed by	15. Decedent's Education (Sp	ecify only highest g	rade comple			s Usual Occupation			16b. Kind of		
6 172 h an "n cal Es	lete	Elementary/Secondary (0-12	2) College	(1-4 or 5+)		·	-			Rel	iance	9
within giene.	E C	12	(- 1 A)		l	Pa	arts Fi		S Name (First, Middle		<u>tract</u>	ing
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Midd	•		C 349		'		tricia A		•	
212 uld be Ment mark c ever	<u>В</u>	Edward Tho 19a. Informant's Name/Relation	nship (Type, Print)	Fathe	SI 191	b. Mailing	Address (Street a	and Numb	ber or Rural Route N	umber, City or T	Fown, State,	Zip Code)
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiew from 11 riten 27 is marked other than "natural", or other traumatic event, the Medical Examiner.		Edward T. Swe	eenev. Si	rathe	8	397 (Dakwood	Roa	ad, Mille	rsvil	le, MI	21108
Te, I and I and Healt		20a. Method of Disposition 1 Burial 2 Cremati			20b. Place		ion (Name of ceme		Date	20c. Locatio	on - City or T	own, State
Pages nent of		4 Donation 5 Other		i iioiii State		Have	n Mem Pk		09/09/09	Gler	n Bur	nie, MD
Baltimore, permit. Pages I ar Department of Her Important: If ite		21. Signature Funeral Servi				22. Na	me and Address o	of Facility	G.J.Gono	e Fune	eral	Home, PA
		23a. Part I. Enter the disease,	Il Ali Ali -	t savesed the	a death Dani	1169	9 Rivie	ra I	Orive, P	asaden	a, MI	21122 Approximate Interval
Physician /Medical		failure. List only one caus	se on each line.									Between Onset and Death
xaminer		Immediate Cause (Final diseasor condition resulting in death)	se a. Hyper Due to (or as			eros	clerotic	card	liovascula	r disea	ise	
	Ļ	Sequentially list conditions,	b									
	Examiner	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated	c									
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e exe	/Medical	X UNPENDED	AMENDE	_D 23a,	27, per	mE,	g895 9/28	8709	TT			
,- 20		IF FEMALE: 23b. Was decedent pregnant in		s, outcome e birth	of pregnancy	2 Feta	al death 3	Ectopic	pregnancy	23d. Date Montl	e of delivery h D	ay Year
x 68 th certifi tending	Physiciar	past 12 months?	4 Pre	egnant at tim			er (Specify)					•
Box ne death c the atten	hys			known					A DOC DI	l tabanan una ar		he says of death?
Records, P.O. Box 68 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by P	Part II. Other significant cond	litions contributing	g to death b	ut not resultin	g in the ur	iderlying cause giv	ven in Pai				he cause of death? ably 4 Unknown
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cords, law require has been sie 2 should t	Completed								au	opsy formed?	prior to co death?	ompletion of cause of
	Co						00 B)	1 D 41 4		2 V No	1 Ye	s 2 No
Vital ysician: his certif director,	Be	25. Was case referred to medi examiner?	Hospital:	Inpatient	2 FR/C	utpatient		of Death ((Check only one) Nursing Home 5	Residence	6 Other	Scene
of Vit g Physic ter this teral dir	.T	1 ✓ Yes 2 No 27. Manner of Death	28a. Da	ate of Injury		Time of In	0			e how injury oc	bromd	
on on ending ath.	tion		ending	onth, Day,Year)		1Ye	es 2	No			
Division of Vital Records, state or Attending Physician: The law requirated retreets. After this certificate has been select in by the funeral director, page 2 should	ifica		vestigation 28e. Pl	lace of Injur	y - At home, f	arm, stree	t, factory, office bu	ilding, etc	c. 28f. Location or Town		ımber or Rui	ral Route Number, City
Division of Vital Into Hospital And Hospital And Adentury Hours after death of the Funeral Director: After this certifupletely filled in by the funeral director,	Certification:	4 Homicide	termined (Specia	-					0			
Division of a Division of attending Ph within 24 hours after death. To the Funeral Director. After t completely filled in by the funeral	Medical	Chack anh. Certifying	Physician: To the bas xaminer: On the bas and manne	is of examir	nowledge, de nation and/or	ath occurr investigati	ed at the time, date on, in my opinion,	e and pla death oc	ce, and due to the ca curred at the time, da	iuse(s) and mar te and place, ai	nner as state nd due to the	ed. e cause(s)
To To com	Me	29b. Signature and title of cert		er stated.			29c. License	number		29d. Date s	signed (Mor	nth, Day, Year)
		/ //	/(_				O.C.M	1.E.		Septem	ber 5, 20	09
00::		30. Name and address of pers					Donn Street	Doll:	oro MD 24204			
00M€	ate	Mary G. Ripple MD. 31. Date filed (Month, Day, Yea	Deputy Chie	Registrar's	Signature -		rein Street,	Daitimo	ore, MD 21201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 3:00 AM Frederick Scott Thomason 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Franklin Square Hospital osedale Baltmore Birthplace (State or Foreign Country) Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 🔀 M 2 🗆 F 212-42-1454 63 Director Dec.7, 1945 MD Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d, Inside City Limits 10b County 10a. State er than "natural", or items 23a or 28a-f show the Medical Example remust be notified at 1 ☐ Yes 2 No Baltimore Directo Essex 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 410 Mace Avenue 21221 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 □¥es 2 □ No 11. Marital Status 1 ☐ Never Married 2 🙀 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Dry Wall Construction 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Elmer Thomason ဥ Thelma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Thomason wife Mace Avenue Baltimore MD 21221 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 3 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dopatish 5 ☐ Other (Specify) Bayview Crematory 9/11/09 Baltimore MD 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signylun of Funeral Service Licesee Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sastric **Physician** ancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760€ Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by artery disease, Chronic OBSTUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown pulmonary distas 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 **N**0 1 ☐ Yes 1 ☐Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 7, 2009 D63054

State Registrar DHMH 17 Rev 1/2001

Maryland 21215-0036

Thomas an,

9000 Franklin Square Drive, Battimare,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD,

Cina,

31. Date filed (Month, Day, Year)

			Pleas	e Type or Pri State of M		I / Depa	rtment of I	Health and M			ble.	20000
						Cert	tificate of	реатп	0.0-1- 15	Reg. No.	177 6	TOUL
	Physicia	an	Decedent's Name (First, Middle, I	,					2. Dete of De Month	Dey	Year	Time of Death
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	° Funeral		Social Security Number 6	. Sex 7. A	ge (In yrs. la		If Under 1 Year Months Days		8. Date of Bir (Month, Da	ay, Year)	9. Birthplace Country)	(State or Foreign
	Director		215 30 4045 Usuel Residence of Decedent	1 M 2 L	99	Yrs.			04/22	/1910	Penns	y1vania
3	ž		10a. State 10b. County		10c. City,	Town or Loc	ation				10d. I	Inside City Limits
	E P	ţ	Maryland Anne	Arunde1	В	altimo	re					1 ☐ Yes 2 🖾 No
4	128	rec	10e. Street end Number				10f. Zip Code			10g. Citizen of V	What Country?	
1	238.0	aiD	5214 Disney Av	renue				1225		U.S.	.A.	
		Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	?	. 13. W	as Decedent of Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No Rican, etc.)	o- 14. Rac Blac	e - American II ck, White, etc.	ndian,
220	perim. Tages I end. Subunder little within 72 hours are dean with the waryend performant of Health and Mehral Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Ď.	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:		1	□Yes 2 1 No	Specify:		Specify	Whit	е
	natur Isali	Completed	15. Decedent's (Specify only highest)	Education		16a. Decede	ent's Usual Occu	pation during most of world)	kina	16b. Kind of Bi	usiness/Industr	у
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	od off	Be	17. Fether's Name (First, Middle, La	Charles K	Coontz				.ce Beck			
<u> </u>	mark mark	ဥ	19a, Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (Stree	t and Number or Ru	ral Route Numb	er, City or Town,	State, Zip Coo	de)
	ith ar 27 is r trau		John Tyler / So			4700	Water P	ark Drive	Unit D	Be1cam	ip, MD.	21017
ָּט ע	Item othe		20a. Method of Disposition		20b. Pla	ce of Dispos	ition (Name of atory or other pla	ace)	Date	20c. Location -	City or Town,	State
	nant c int: if iny or		1 XBurial 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spe		3		1 Cemete		9/12/09	Baltim	ore, Ma	ryland
2	Deperting Injury		21. Signature of Funeral Service Lic	censee	1	22.	Name and Addr	ess of Fecility Go		neral Se		
	85588		Home, M.	ramerio	2/124	14		chie Highv	_		Maryla	ınd 21225
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	hysician /Medical		Immediate Cause (Final				. ^				, on)
	Examiner		disease or condition resulting in death)	е			NH _				10	do4/3
		Je.			Due to (or	as a consequ	ience of):				-	,
k, 3	on and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate	b	Due to (or	as a consequ	ience of):					
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Y	ding se es	Me		d								
	ettan	clar	Part II. Other significant conditions	a contribution to doubt	hut not social	tion in the un	dorlying course a	iven in Part I	23h Did	tobecco use co	intribute to the	cause of death?
	by the	Physician/M	Fartii. Other significant conditions	s contributing to death i	Dut not resun	ang in ale an	denying cause g	Well III Fait I.		Yes 2 No		ly 4 □ Unknown
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5	equile	ted Pd								s an autopsy ormed?	availab	eutopsy findings ole prior to etion of cause
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5 5	a fune	tion	1 Natural 5 ☐ Pending investigat		ay Year)	Injury		ork?]Yes 2∐No				
2 4	or dee octor by th	Certification:	3 ☐ Suicide 6 ☐ Could not determine	200. PIECE OI II	njury - At hon	ne, farm, stre	et, factory, office)		(Street and Numi	ber or Rural Ro	oute Number,
<u>:</u>	e Dir			Janaing, o	no. (opcony)							
To the Breatlet of Attendand Districts The few requires that the death continued to	Within 24 hours after deeth. To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funerel director, page 2 should be detached for use as the bunk-transit	edicai		Physician: To the best aminer: On the basis of end manners	of exemination							
2	vithin Co th compl	Me	29b. Signature and title of certifier					se number		29d. Date signe	ed (Month, Day	, Year)
	Z,- 0			7	-	\bigcirc		037577	>	Septen	mb- 8,	19005
	3		30. Name end eddress of person w	no complete cause of	death (Item	23e) (Type, F	Print)	D37577	reston	WA	21136	
	Stat Registra		31. Date filed (Month, Day, Year) SEP 1 0 2009	Sevent 32: Regist	trar's Signatu	back	,					

1-

Physician

/Medical

Examiner

Be Completed by Funeral Director

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Examiner

Medical Certification: To Be Completed by Physician/Medical

Funeral

Physician /Medical Examiner

61	
Sta Registr	
DHMH 17 Rev 1/2	001

For State Registrar		2.3.00			ertificate of	Health and N <i>Death</i>		leg. No.	0 10	2000
. Decedent's Nam	e (First, Middle,	Last)					2. Date of Dea	th	W 11 7	3. Time of Death
Merri	Ltt	Walbri	dge	Thu	ırlow		Septemb	er 8,	2009	10:45 p⅓
a. Facility Name (If not institution,	give street and nu				or Location of Death	I		nty of Death	
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Social Security N		6. Sex 1 □ M 2 □ F		s. last birthday Yrs.	Months Days		8. Date of Birth (Month, Day Sept. 2	Year)	9. Birthp	
072-22-3 sual Residence o		-X	82	118.			Sept. 2	1, 192	y was	shington
a. State	10b. County		10c. (City, Town or L	ocation				1	10d. Inside City Limits
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e. Street and Nu					10f. Zip Code			10g. Citizen	of What Cour	ntry?
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. Marital Status		Armed Fo		U.S. 13	. Was Decedent of I if Yes, specify Cub	Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No-	14. F	Race - Americ	
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Elementary/Seco	ondary (0-12)	College (1-4or 5+)	l	emaker	,		0wn	Home	
	(First, Middle, La			,		18. Mother's Nam	ne (First, Middle,			
	McCully					Ethel Wa	albridge			
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a. Method of Dis	<u></u>			. Place of Disp	position (Name of ematory or other pla	200)	Date 1.0	20c. Location	on - City or To	own, State
	Cremation 3 5 Other (Spe	3 ☐ Removal from ecify)	State Ch		ke Cremato	sepi	t. 10, 009	Belts	sville	, MD.
	uneral Sarvice Li					2 1 21	1			on Service
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30. Name and Reena Ranpur 31. Date filed (Month, Day, Year)

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

resa L. Willis	1	State of Maryland / Department of F -For State Certificate of E		/gierie Reg. N	. 201	10 2000
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	/ Year	3. Time of Death
edical Exami	ner	Teresa Lynn Willis	. City, Town, or Location of Death	September 6,	2009 4c. County of Death	1225 1115
		Tac. I dom't Hame (il not maintain) give the end of	Rosedale		Baltimore Cour	nty
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 43 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min.	8. Date of Birth (M 05/23/	M/DD/YYYY) g. Birth 1965 Foreign Cou	nplace (State or MD nhtry)
w any	-	Usual Residence of Decedent 10a. State	1			10d. Inside City Limits 1 Yes 2 No
ne Maryland or 28a-f show	Director	10e. Street and Number 5212 Kenwood Ave.	10f. Zip Code 21206	10g. (Citizen of What Coun	try?
after death with the Maryland al", or items 23a or 28a-f shinger must be notified at once	Funeral D	1 Never Married 2 Married Armed Forces? If Yes 2 No	Decedent of Hispanic Origin? (Sp. specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ White, etc. Whit	
after cral", o	by F	3 Widowed 4 Divorced If Yes, Give Yeer 1 1	Yes 2 No specify:	work done 16	Specify: b. Kind of Business/li	
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MD 21215-0036 2 should be filed within 72 hour b 7 and Mental Hygiene. 1's marked other than "matt martic event, the Medical Exar	Be Corr	17. Father's Name (First, Middle, Last) Unl	R. Bett	e (First, Middle, Maid ty Ann W	illis	
MD 21; d 2 should b lth and Men n 27 is mar	To	Cecilia Walton/Sister 3509	Address (Street and Number or Woodring Ave	e. Balto	, MD 212	234
Baltimore, MD 2 permit. Pages I and 2 should Department of Health and M Important: If item 27 is m injury or other traumatic e		1 Burial 2 Cremation 3 Removal from State Chesapea			oc. Location - City or eltsvill	
Balti permit. Departu Imports		571 MO0302 671	ame and Address of Facil AF 7 Green Pasti	ures Dr.	Balto,	MD 21286
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive atherosc				Approximate Interval Between Onset and Death
aminer		or condition resulting in death) Due to (or as a consequence of):				
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687 certifica nding p	Physician/M	past 12 months? 4 Pregnant at time of death 5 Oth	al death 3 Ectopic pregr	nancy		Day Year
र्व के व	1 -	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.			the cause of death?
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tal Rec cian: The l certificate l	S	25. Was case referred to medical	26.Place of Death (Chec	1 Yes 2	No 1 Y	es 2 No
/ital ysician his cert directo	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatient	IOthor:		esidence 6 Oth	er:
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been s completely filled in by the funeral director, page 2 should the	ation: T	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	1 Yes 2 No	28d. Describe ho		
Divisi pital or Att ours after de eral Direct	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, Sta	te)	Rural Route Number, City
To the Hos within 24 hd To the Fun completely	Medical (29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.	red at the time, date and place, a tion, in my opinion, death occurred	d at the time, date ar	nd place, and due to	the cause(s)
€ ≥ € 8	Me	29b. Signature and title of certifier Number Strassel	29c. License number O.C.M.E.	1	September 7, 2	
		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 F	Penn Street, Baltimore, M	D 21201		
Regi	State		Kal			
DHMH 17 Rev 1		ORIGINA				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Day 5, 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:45 AM Douglas L. Wink September 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Summitt Park Health & Rehabilitation Baltimore Catonsville If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 0272071922 1 XM 2 ☐ F 87 212-18-0552 Maryland **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy lijury or other traumatic event, "In Maryland Eximiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5723 Edmondson Avenue 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: þ White 3 Widowed 4 Divorced 43-45 Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Andrew P. Wink Marie Downey ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Doris Wink - Wife 5723 Edmondson Avenue Catonsville, Maryland 21228 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09/11/2009 Baltimore, Maryland Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
David J. Weber Funeral Homes P.A.
5311 Edmondson Avenue Baltimore, Maryland 21229 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List foly of e cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as cons at nece of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760, resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Day Year 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performa 2 🗆 No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Deat 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 🗌 No Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The physician is the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

		For State	Plea	se Type or State o		and / D)epa		lealth and M	Mental Hyg	giene	egible.		
	_	State Registrar 1. Decedent's Name	e (First Middl	e Last)			Cer	uncate of	Dealli	2. Date of Dea	th	444	3. Time of Death	
Physicia		George	Whyt							Septembe	Day 3.	2009	115 AM	
/Medic Examin		90.10		n, give street and nu	mber)			4b. City, Town, o	r Location of Death			ounty of Deat		
	•	Augsburg	Luthe	can Hon	ne			Gwynn Oa	K T If Under 24 Hrs.			Baltimore 9. Birthplace (State or Foreign Country)		
Funeral		5. Social Security		6. Sex 1 M 2 F	7. Age (In)			If Under 1 Year Months Days	Co	hplace (State or Foreign untry)				
Director		219-28-12 Usual Residence of		nes m ee		79	Yrs.			April 09	9, 1930 MD			
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or 28	Dire	10e. Street and Nur						10f. Zip Code		10g. Citizen of What Country? USA				
ath w	Funeral Director	4010 Buc	kingham		1	21207				ole and the second				
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illed v Hygie ther t	ပ္ပိ	17. Father's Name	(First. Middle.	Last)		(Gen	eral	Service A	18. Mother's Nan	ne (First, Middle,			rment	
d be i ental ked o	To Be		H. Whyt						Beatric	e Carroll				
shoul and M s mar umati	F	19a. Informant's N				19b	. Mailin	g Address (Street	t and Number or Ru	ıral Route Numbe	er, City or	Town, State, 2	Zip Code)	
and 2 saith a n 27 is		Myrna W.	Pugh /	Sister			4745	Bonnie Br	ae Road Pik	esville, M				
Firence or oth		20a. Method of Dis	•	3 ☐ Removal from	State 20	 b. Place of cemeter 	Dispos ry, crem	sition (Na <i>m</i> e of natory or other pla	ce)	Date		ation - City or		
t. Pag tmen tant: ijury		4 Donation	5 Other (S	Specify)		arrisc		rest VA Ce)/11/2009		ngs Mill		
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To the Hospital or Attendia within 24 hours after death. To the Funeral Director; P completely filled in by the fu	Medical	29a. Certifier (Check only one)	1 ☐ Certifyi 2 ☐ Medical	ng Physician: To th I Examiner: On the l and mar	e best of my basis of exar nner stated.	nination ar	e, deati nd/or in	n occurred at the vestigation, in my	opinion, death occ	e, and due to the urred at the time,	date and	place, and du	e to the cause(s)	
To the vithin To the Co⊞p	Me	29b. Signature and	title of certifie	er				29c. Licer	se number		29d. Date	e signed (Mon	th, Day, Year)	
,		L.	S o	KIND				R144	1682		Septen	nber	4, 2009	
24:1		30. Name and add		who completed cau	se of death	(Item 23a)	(Туре,	Print)	1	0 21121				
Sta	te.	31. Date filed (Mon	nth, Day, Year,	Main St.	Registrar's S	ignature	00	Keisters	town, M	V LIISE	•			
Registr			EP 10	2009 Ben	wa	A. ,	par	Red						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 12:20 P M Year **Physician** 2009 Aguila Aaron Watkins September 06, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Manorcare HealthServices - Woodbridge Catonsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days D.C. Director 219-22-1227 August 06,1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State f show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 Tyes 2 No Director MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3700 Seven Mile Lane, Apt.A1 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: African-American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Truck Driver Baltimore City or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any Injury or other traumatic ev Andrew Watkins Eva Criffer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Anna Watkins / Wife 3700 Seven Mile Lane Pikesville, Maryland 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09/14/2009 Owings Mills, Maryland Garrison ForestVet.Cemetery 22. Name and Address of Facility Wylie Funeral Homes P.A. of Balto. Co. 21. Signature of Funeral Service Lice 9200 Liberty Road Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à RAUT INFECTION 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? URONIC 24a. Was an certificate has birector, page 2 sl autopsy performed' 1 □Yes 2 No 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Sqursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 XNo Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D5059107 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2)136 UMP BUSINESS NO 31. Date filed (Month, Day, Year) SEP 1 0 2009 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene-1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** John Leroy Waters, Jr. 200 /Medical 4b. City, Town, or Location of Death 4c County of Death Baltimore 4a. Facility Name (If not institution, give street and number) **Examiner** Randallstown Seasons Hospice/Northwest Hospital Birthplace (State or Foreign
Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Feb. 26, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days Hours 1,□ M 2□ F 214-44-9433 1946Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show traumatic event, the Medical Examiner must be notified at Baltimore N/A1√2 Yes 2 No Funeral Director 28a-f Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò USA 21215 5009 Litchfield Avenue or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 💢 No Black, White, etc Specify: Black 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) 8th grade College (1-4or 5+) Public Schools Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Loretta John L. Waters, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5009 Litchfield Avenue Baltimore, MD 21215 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any Injury or other traur Dorothy Waters/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 9/10/09 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Maryland King Memorial Park 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Olon Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLD COURT Rd Randallstown ton 5401

Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, ITEM#10b, c.d.19b, perFH, 6895, 9/10/09, WS State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Wells 2009 11:56PM Hapsie D. 9 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford 917 Towson Drive Abingdon 8. Date of Birth (Month Day Year) 4-25-1933 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months Days 1 □ M 2**½** F Hours Min. N.C. 213-30-1792 Usual Residence of Decedent 10b. County Harford 10a. State C. City, Town or Location
Abingdon 10d. Inside City Limits TZYes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 917 Towson Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Black 1 □Yes 2 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) College Manor N/H Care Taker <u>10th grade</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Owens Wesson Cora Bell Manning 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Nymber or Rural Route Number, City or Town, State, Zip Code)
917 Towson Abincon, MD 21009 Abingdon, MD 21009 Mowana Russell-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🛣 Cremation 3 🗆 Removal from State 9-10-2009 Baltimore, MD Greenmount 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 13 1- milh Balto, MD 21202 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Years disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this certificate or Attending death. s after death

physician and s the burial-transit the aftending ploched for use as the detached signed h cate has been signated by page 2 should b funeral director

Physician

/Medical

Examiner

Director

Funeral

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Completed

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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

ital Hygiene. od other than "natural", or items 23a or 28a-f show event, the "notical Examiner must be notified at

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permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tra

Physician

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Physician/Medical ģ Completed Be Certification: To

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To the Funeral L cal

R. Grunwald 31. Date filed (Month, Day, State Registrar

(Check only one)

29b. Signature and title of certifie

29a, Certifier

and manner stated.

MD

29c. License number D68982

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

September 8,2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tohns Hopkins Hospital 600 N. Wolfe St., Baltimore, MD 21287

32. Registrar's Signature

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Registrar SEP 10 2009 Lenter A. Sparker	-		John Doluin, M.D 7505 Osle		? TOWSO	n, NID	21264
	Regis	strar	SEP 1 0 2009 32. Registrar's Signature	add			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** JAND9L 72: 45 M AUGUS 78, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MM LOPK, NS BALTIMORS NS BAYVIEW 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 31, 1957 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F Months Days Hours 218-48-3911 51 Aùg Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or nitems 23a or 28a-f show any or other traumatic event, Ir. Medical Exp. Item In the nutflied at Iry or other traumatic event, Ir. Medical Exp. Item I. 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County Funeral Director 1 √Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 817 Fort Avenue 21230 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2 🗖 No Specify þ Specify: white 3 Widowed 4 Divorced Completed UHA 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) beverage unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau William Hunt/friend 817 Fort Avenue Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 21. Signature of Funeral Service L Ronald S 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. A ter the disease, it complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau: Final disease or condition resulting in death) **Physician** SUSTOI /Medical Due to (or as a donsequence of): Examiner ESPIRATO Sequentially list conditions r any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and HWOXIC BRAIN Due to (or as a consequence of) Physician/Medical ARDIAC IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2000No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2√2 No Other: 4 \(\square\) Nursing Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No the 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Registrar's Signature 10

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 200 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Doris Mae Wadsworth 11:58 A.M 2009 September 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Months Days Hours Min 217 26 2876 78 Maryland 01/03/1931 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Anne Arundel 1 ☐ Yes 2 📉 No Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 Franklin Avenue U.S.A. 21225 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2**K** No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Secretary Balto. City Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Millard Thomas Sr. Mae Groves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Schley / Son 1900 Casadel Avenue Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 09/04/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility 21. Signature of Juneral Service Licen Gonce Funeral Service. P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or \ a consequence of): Sequentially list conditions, if any, leading to immediate cause. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of death? autopsy perform e5-1 1 ☐ Yes 2 No 2 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 → No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No ☐Could not be

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner certificate be execu Box 68760, P.0. Division of Vital Records, the Hospital or Attending

and attending physician for use as the buria signed by the a page 2 certificate After after death Director: / filled in I e Funeral C

Physician

/Medical

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28a-f show

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Certification:

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

designed

ed other than "natural", or items 23a or 28a-f shorevent, the Medical Examinar is ust by nothed at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item Z7 is marked other than 'any injury or other traumatic event, traumagness.

Physician

* /Medical

with the Maryland

death v

filed within 72 hours after

Baltimore, Maryland 21215-0036

Medical completely within 2

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day,

determined

30. Name and address of perspn who completed cause of death (Item 23a) (Type, Print)

Chur

MD Anne Avandel Medical Centr 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0005829

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MAURICE 00 07 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A JOHNS HOPKINS BAYULEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Date of Birth (Month, Day, **Funeral** Days Hours 1 📆 M 2 🗆 F 85 04/13/1924 245 38 6109 North Carolina Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Wedical Evantinal must be notified at once. 10a State 10b. County 10c. City, Town or Location 1 XYes 2 No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21225 U.S.A. 3920 - Sencond Street Funeral 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Types 2 No
If Yes, Give
Year or Dates: 1964 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify à 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Radar Inspector Westinghouse 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewie W. Wentz Emeline Hough ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3920 - Second Street Eva Wentz / Wife Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD State Veteran Cem. 09/14/2009 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee namesouski 4001 Ritchie Highway Baltimore, Maryland 21225 Long 23a. Part 1. Enter the disease, a complications that caused the shock, or heart failure. List only one cause on each line. omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** FAILURE 12 HOURS /Medical Due to (or s a consequence of): **Examiner** 24 HOURS 4RAM - NEGATIVE ROD If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760%Due to (or as a consequence of): Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 □Yes 2 ☑No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie SEPTEMBER 07,2009 RES-DOC

10+1

State Registrar

SEAN ACBOR-ENOH MD, PHD 49
31. Date filed (Month, Day, Year)
SEP 10 2009
SEP 10 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #26, pstate of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day Year SEPTEMBER 7, 2009 7:55a' JO-BARBIE WALKER 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE 1160 WINTERSON RD. LINTHICUM 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 7 F 577-48-8836 12-29-1934 MISSISSIPPI Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No MD BALTIMORE GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8053 GREEN LEAF TERRACE 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 Never Married 2 Married 1 ☐Yes 2 If Yes, Give 2 No 1 ☐ Yes 2 ▼No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSE HEALTHCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH CAMPBELL MOZELL TAYLOR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBIN WALKER (DAUGHTER) 8053 GREEN LEAF TERRACE GLEN BURNIE, MARYLAND 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other Cremation 3 Removal from State 5 Other (Specify) MT. OLIVET CEMETERY 9-21-2009 WASHINGTON, DC D. HIBNER^{2.} Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ME THAT MATE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 22d Date of deliver

Physician / /Medical Examiner requires that the death certificate be executed

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygin Important: If item 27 Is marked other any Injury or other traumatic event, III.

Physician

/Medical

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Director

Funeral

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Funeral

Director

ed other than "natural", or items 23a or 28a-f show event, it a Medical Examinar must be notified at

death with the

72 hours after

Baltimore, Maryland 21215-0036

burialattending physician for use as the buria Physician/Medical signed by the a Be Completed by has page 2 s certificate director Certification: To n 24 hours after death.

le Funeral Director: A
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Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The

in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		topic pregnancy ner (specify)		Month Day Year
Part II. Other significant conditions cont	ributing to death but not resulting in the under	lying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
			24a. Was an autopsy performed?	
25. Was case referred to medical		26. Place of Dea	ath (Check only one)	
examiner? 1 ☐ Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	□ DOA Other: 4 □ Nursing H	Home 5/1 Residence	6 Nother (Specify) Hotel
27. Manner of Death 12 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inj	jury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier (Check only one) Certifying Physical Certifying Physical Examination (Check only one)	cian: To the best of my knowledge, death oc er: On the basis of examination and/or invest and manner stated.	curred at the time, date and plac gation, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier	PHYSECIAN	29c. License number	29d. E	Date signed (Month, Day, Year)
De Res	gel landy-	MD D0066	507	9/08/2009
	poleted cause of death (Item 23a) (Type, Prin	MD DOSGE NAMISH PAR NEENE SMEET		1001E MA 21201

Medical

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 130 AM SAMUEL C. YOUNG Patember 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore-Washington Medical Ceneter Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Months 1**X** M 2□ F 213-14-0383 87 August 4, 1922 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7944 Elizabeth Road 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐Yes 2 No White Specify. Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Roper Eastern 12 Maintence Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel C. Young Lillian Reedy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred C. Young (Wife) 7944 Elizabeth Road, Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National Cem. Sept. 11, 2009 Catonsville, Maryland 22. Name and Address of Facility 21. Signature of Euroe al Service Lice see ^{2. Name and Address of Facility} McCully—Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 art 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as car inc or respiratory arrest, mediate Cause (Final ume de al disease or condition resulting in death) Duato (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as consequence of) 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

Physician

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ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the "Middeal Examinat" is not be notified at

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Pages 1

Health a

Department of Heal Important: If item 2 any injury or other once.

Baltimore, Maryland 21215-003

Examiner attending physician and for use as the burial-tran been signed by the should be detached Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed

After

within 24 hours a

Division of Vital Records, P.O. Box 68760,

Physician/Medical þ Completed Be

cal

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 hpatient

28a. Date of Injury (Month, Day, Year)

autopsy 2 1 No

2 ER/Outpatient 3 DOA

28b. Time of

Injury

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ №6

29b. Signature and tit/9 of certifie

27. Manner of Death 1 [[Natural 5 Pending investigation 2 Accident

6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier 1 👺 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Year)

Hospital:

29c. License number

29d. Date signed (Month, Day, Year)

1 □ Yes

2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) To bake and

32. Registrar's S

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P.O. Box 68760,	he law requires that the death certificate be executed
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ı of Vita	g Physician:

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	,		State Registrar 1. Decedent's Name (First, Middle)	a last)	Ce	rtificate of	Death	2. Date of Dea	th Page No.	309	3. Time of Death	
	ysicia Medic	_	T. Decoderit's Harrie (1 mai, mindan	HELFN		ZYLKA		Sept. 9,	Day	Year	5:00 A M	
	amin		4a. Facility Name (If not institution Peartree House	n, give street and number) Assisted Living			r Location of Death adena		4c. County of Death Anne Arundel			
Fun	neral		5. Social Security Number	6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)				
	ctor		212-10-5368 Usual Residence of Decedent	92	Yrs.			June 2,	1917	Mar	yland	
aryland show	d at	٦	10a. State 10b. County		City, Town or Lo					1	I Od. Inside City Limits 1 ☐ Yes 2 ☑ No	
r 28a-f	notifie	Director	Maryland Anne 10e. Street and Number	Ardider	1 asaden	10f. Zip Code		1	I0g. Citizen of	What Cour		
ath with	ust be	ra D	662 D Street				21122			SA		
paritimore, intal yiality 212.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem Z7 is marked other than "natural", or items 23a or 28a-f show	xaminer m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	If Vac Give	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 No	pecify Yes or No- Pican, etc.)	14. Ra Bla Speci	ace - Americack, White, $_{ify:}$ Wh			
72 hou natura	lical E		15. Deceden	t's Education st grade completed)	16a. Dece	edent's Usual Occup	oation during most of work	ina i	16b. Kind of E	Business/In	dustry	
within ene.	he Mex	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	e kind of work done of DO NOT use retired Housew		9	Ow	n Hom	е	
Should be filed withing and Mental Hygiene.	vent, I	Be C	17. Father's Name (First, Middle,				18. Mother's Nam			me)	-	
y la hould b d Meni	natic e	ပ	Stanislaus 19a. Informant's Name/Relations	Orzewicz	10h Maili	ing Address (Street	Mary Mary	Sparr		- State Zi	n Cadal	
Tand 2 sl Health an Hem 27 is i	er traus		Janet M. Topper		662	•	et, Pasad					
Pages 1 anent of He	or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from State 11		osition (Name of ematory or other place		Date / 2000	20c. Location	•		
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Dep in	any ir		hand	1 Com		2. Name and Addre IcCully-Po 3204 Moun	olyniak F tain Road	uneral H , Pasade	ome P. ena, Ma	A. rylan	d 21122	
Physic /Med			a. Part : Finter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	entid	ter the mode of dyir	ng, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death	
Exam	iner	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	b. Due to for as a cons	sequence of):	e Heen	t Fa	(WH	-	\dashv	3 years	
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and	5	al Examiner	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):	juel (1)	W)				royears	
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the death ce y the attendi	detached for use	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preduced the second	etal death 3	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	су			ate of deliv Month	very Day Year	
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a b a	era	⊢⊦	27. Manner of Death . 1 Natural 5 Pendir	28a. Date of Injury	28b. Time of	IN 3 L DOA	4 LI Nursing H	ome 5 ☐ Resid 28d. Describe h			Ty)-10313/5/210	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attention	in by the fu	Certification:	2 Accident investing 3 Suicide 6 Could determ	gation not be 280 Place of Injury A		M 1 🗆]Yes 2□No	28f. Location (S City or Tow		nber or Rur	al Route Number,	
he Hospital n 24 hours he Funeral	pletely filled	edical Co		ng Physician: To the best of my Examiner: On the basis of exam and manner stated.								
To th withi	сош	Ĭ	29b. Signature and title of certifie	t Short	MD	29c. Licens	se number 20094		29d. Date sign	ed (Month,	Day, Year)	
	Stat	te	30. Name and address of person 31. Date filed (Month, Day, Year)	1 baty MD.	1411	Modus.	a fail	- Pra	t, Old	Bull	rie, and 2106,	
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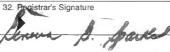
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ZOLLICOFFER **Physician** BETTIE 9:20PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE GOOD SAMARITAN HOSPITAL OF BALTHORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day Year) 05/10/19/2 Days 1 □ M 2 🔀 F Months Hours Director Usual Residence of Decedent 10a. State NC filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 23a or 28a-f show the Medical Examiner must be notified at **Halifax** Littleton KU/tiMOKE 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 2457 Roper Springs Rd. 10f. Zip Code USA 27850 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married o, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Black 3 Widowed 4 □ Divorced Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) me maker Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, It once. 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last Be Pages 1 and 2 should be f ment of Health and Mental I ၉ 19a. Informant's Name/Relationship Winston Avenue Baltimore, Manyland 21259 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory of other 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL INFARTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed HYPERIENSION YEARS use as the burial-tran Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by PNEUNONIA DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown OBESIT 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy of Vital 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Division 5 Pending investigation death. 1 ☐ Yes 2 No 2 Accident after death the 1 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospital within 24 hours a 29a. Certifier recertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number
RESOO 7 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VICENT MACO

State Registrar 31. Date filed (Month, Day, Year)



ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2009 9:47 P M AUGUST 24 CONSTANCE ATABONG /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min Days 1 □ M 2 🖸 F Yrs MAY 5 1962 CAMEROON 47 Director 224-27-5453 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is a fine finance in contact. 1 Yes 2 No Director PRINCE GEORGE'S GREENBELT MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20770 USA 9140 EDMONSTON COURT # 301 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married Married BLACK 1 ☐ Yes 2 ☐ No Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 4YRS NURSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DAVID ASONG GRACE ASONG ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 9140 EDMONSTON COURT #301 GREENBELT, MARYLAND 20770 FIDELIS ATABONG/HUSBAND Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ဩ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/18/2009 MENJI, CAMEROON FAMILY PLOT 4 Donation 5 Other (Specify) Signature of F neral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC UTERINE CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner the to (or as a number using of) sician and burial-transit Exami RESPIRATORY FAILURE Due to (or as a consequence of) physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 mon 1 ☐ Yes 2 🕅 No Pregnant at time of death 5 Other (specify) signed by the a 9 Dlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown cate has been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined

The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records,

Maryland 21215-0036

altimore,

Hospital or Attending Physician: death. after death Director; filled in by the within 24 hours a

To the Funeral D

State Registrar

DELROY ANGLIN 31. Date filed (Month, Day, Year)
AUG 2 6 2009

who co

3 ☐ Suicide

29a. Certifier

Medical

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

30 Name and address of person

M.D. 1500 FOREST GLEN ROAD SILVER SPRING, MARYLAND 20910 32. Registrar's Signat

spleted cause of death (Item 230) (Type, Print)

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D55148

29d. Date signed (Month, Day, Year)

AUGUST

25, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Months Year **Physician** 745 M NSEZ ESTHER /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Anne Arundel 1169 Bacon Ridge Road Crownsville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2**Z** F Hours 175-05-9261 91 Director 9/22/1917 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Micrical Examples. 10a, State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Crownsville MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21032 USA 1169 Bacon Ridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify. ģ Specify: White 3 Midowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Anna Doll Saupe Eugene 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther A. Dawson/Daughter 1169 Bacon Ridge Road, Crownsville, MD 21032 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem. 8/24/2009 Crownsville, Maryland 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 0 6512 NW Crain Hwy., Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Pont. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) lan Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a Was an autopsy 1 ☐ Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1∐Yes 2√No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 □Yes 2 □No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this cartificate has been always and a feet of the first promiting the properties. Box 68760. P.O. Records, Division of Vital completely

> State Registrar

within 2 To the I

4 Homicide

(Check only one)

29b. Signature and tile of ceffifier

Name and address of person w

29a. Certifier

ENTA

and manper stated.

32. Redistrar's Signature

441

completed cause of death (Item 23a) (Type, Rrint)

W

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

amend 20a-22 per hosp 10/09 14h Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 27 per Dr. g893 7/10 Continuente of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 2004 /Medical Name (If not institution, give street and number) 4b. City. County of Death Examiner If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** Months Days 1 M 2 F Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or items 23a or 28a-f show kry or other traumatic event, the Macdical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) INVE-IN 17. Father's Name (First, Middle, Last) Be ပ mant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 20b. Place of Disposition (Name of cometery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) hosp. dis. 6/9/09 Cheverly, MD Injury Prince Georges Hosp. 21. Signature of Funeral Service Licensee 22. Name and Ad ress of Facility Impo Iny li Marie P. Mutchler prince Georges Hospital 3001 Hospital Dr. Cheverly, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Monyialle /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? detached for Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by page 2 should be Jabets 5 2 100 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 Yes 2. No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 1 npatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Medical Certification; 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗆 No death in by the 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide o the Hospital filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29b. Signature and title of certifier 29c. License number 30. Name and address cause of death (Item 23a) (Type, Print) person who compl

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#1.PerPhys.PGC8-27-09crCertificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Lage **Physician** В. /Medical 4a. Facility Name (If not institution, give street and number County of Death Examiner LAURE REGIONAL HOSPITAL If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. **Funeral** 1 M 2 X F Months Days Hours Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show Item 27 Is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Prince Georges Beltsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11418 Pitsea Drive 20705 Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes AV No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Married 1 ☐ Never Married 2 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Private Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank William Bowles, Sr. Jacqueline Woodward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander Brown - husband 11418 Pitsea Drive, Beltsville, MD 20705 Health tem 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or c 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resummention Cemetery 10/20/2005

22. Name and Address of Facility Bell and Johnson Funeral Home, P. A. 21. Signatu 6503 Old Branch Ave., Temple Hills, MD 20748 Enter the disease, or comp , or heart failure. List only d ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death Imme Cause (Final Physician Anoxic Encephalopathy disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sersis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Pneumonia burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician The law requires that the death certificate be Physician/Medical as the t IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Dav Year 5 Other (specify) 1 ☐ Yes 2 🔀 No 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' 1∏ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 1 X Inpatient 2 ER/Outpatient 3 DOA this (27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral I Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0055703 8/21/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year ALIC 9. 7 2009

Tsion Berhane, M.

301 Hospital Drive, Glen Burnie, MD 21061 32. Register's Sign

		1 - State Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.										
		1. Decedent's Name (First, Middle, La.	st)						2. Date of Death 3. Tin				
Physic /Med		Harold	McDona1	ld Bra	thwait	:e		Aug	ust	23, 20	Ye ar 09	4:30 P. M	
Exami		4a. Facility Name (If not institution, given springbrook Adve Rehabilitation	ntist No	ber) I rsing	and	Silver	Spring						
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and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation					10	d. Inside City Limits	
Mary f sho	ō	Maryland Montgo	marw		Cilvor	Spring						1 X Yes 2 □ No	
the 28a	Director	10e. Street and Number	шсту		DILVEL	10f. Zip Code			10	g. Citizen of W	hat Count	rv?	
3a o	0	12325 New Hampsh	ire Aver	nue		2090	4			United	Stat	tes	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a It affect Examination of the register at a must be redified at once.	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 □ Yes 2 If Yes, Give Year or Dat	lent Ever in U ces? 2 X No		Was Decedent of If Yes, specify Cub 1 □Yes 2 No	an, Mexican, Pu	? (Specify Ye: uerto Rican, e	s or No-	14. Race	- America , White, e	an Indian,	
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			shock, or heart failure. List	complications that caused the deat only one cause on each line.	h. Do not ent	er the mode	of dying	, such as	cardiac c	or respiratory ar	rrest,		Approximate Interval Between Onset and Death
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o O		Physician/Med	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4☐Pregnant at time of c	leath 5	Other (spec	ciry)						
<u> </u>	g g ij	/ Ph	Part II. Other significant condition	ns contributing to death but not res	ulting in the u	nderlying cau	ıse give	n in Part I.		23e. Did to	obacco us	e contribute to t	the cause of death?
Hecords,	w requires been signe should be	d by	Atrial Fib	rillation						1 🗆 🗅	Yes 2□	No 3□ Pro	bably 4 🔣 Unknown
S	w rec	Completed								24a. Was	an	24b. Were auto	opsy findings available
2	The la	duc									rmed?	death?	ompletion of cause of 2 □ No
Vital		Be C	25. Was case referred to medical					26. Place	of Death	1 Yes 1 (Check only o		1 ∐ Yes	2010
<u> </u>	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 【其No	Hospital: 1 ☐ Inpatient 2X	ER/Outpatier	nt 3 DOA	Othor					□Other (Speci	fy)
0	ding Ph After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	of 280	c. Injury Work	at ?		28d. Describe I	how injury	occurred	
0	endinesath.	atic	2 ☐ Accident investig	ation		М		'es 2 🗆 l	No				
Division or	I or Attend after death. I Director: /	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ome, farm, str fy)	reet, factory,	office		:	28f. Location (5 City or Tov		Number or Rur	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifyin	g Physician: To the best of my kno	wledge deat	h occurred at	t the tim	e date an	d place	and due to the	Called(c)	and manner as	stated
	Hos 24 hc Fun etely	Medical	(Check only one)	Examiner: On the basis of examina and manner stated.	ation and/or in	vestigation, i	in my op	oinion, dea	th occur	red at the time,	date and	place, and due	to the cause(s)
	Fo the vithin Fo the comple	Me	29b. Signature and title of certified	1/1	1.	29c. l	License	number			29d. Date	signed (Month	, Day, Year)
	1- 2F 0		•	IXIV/	M.D	D	0064	4208			Augus	t 25, 2	009
1) 5		30. Name and address of person	who completed cause of death (Iter	n 23a) (Type,	Print)						_	
1			Saadia Husain			Highw	ay,	Rive	rdal	e, MD	2073	/	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ture								

DHMH 17 Rev 1/2001

Physician /Medical Examiner **Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat mast be notified at

Be Completed by Funeral Director Baltimore, Maryland 21215-0036 ၉ Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and been signed by the attending physician and should be detached for use as the burlal-tran Division of Vital Records, P.O. Box 68760, To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number MD D0068080 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

\$\int \text{SIREES HA JALLZ 940} \text{MEDICAL CENTER DRIVE} ROCKULLE MD 31. Date filed (Month, Day, Yea 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

For State Registrar	State of Marylar	•	artment of I		·	giene Reg. No.		10000		
1. Decedent's Name <i>(First, Middle, L</i> as ZELMA	BAUGHMA	N			2. Date of De Month AUG • 24	Day	Year	3. Time of Déath		
4a. Facility Name (If not institution, give SHADY GROVE AI	OVENTIST HO	SPITAI		CKVILI	ΣE	МО	ty of Death			
5. Social Security Number 194-14-7326 11	ex	(last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bir (Month, De	1,192	9. Birthp Cour 3 PEI	place (State or Foreign htry) NNSYLVANI		
10a. State 10b. County MD • MONTGO		ity, Town or Lo	ROCKVII	LLE			1	0d. Inside City Limits Y□Yes 2□No		
10e. Street and Number 9701 VEIRS DE	RIVE		10f. Zip Code	20850		10g. Citizen o	f What Cour USA	ntry?		
11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in L Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 X No	dispanic Origi an, Mexican, Specify:	n? (Specify Yes or No Puerto Rican, etc.)		ace - Americ ack, White, aify: WH]	etc.		
15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	college (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most (d)		16b. Kind of	Business/In	•		
17. Father's Name (First, Middle, Last) GEORGE A. N	MAGILL	211200	71171 01	18. Mother	s Name (First, Middle, ERTA FERN	Maiden Surna	ame)	JV 1 •		
19a. Informant's Name/Relationship (7 KRISTINA HUGHES		1	-		or Rural Route Numb					
20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	20b. Removal from State M E T I	Place of Dispo cemetery, crer ROPOL I	osition (Name of matory or other pla TAN CRI	_{се)} EMATOF	Date RY-8/25/0	20c. Location	n - City or To	own, State		
21. Signature of Funeral Service Lidens		22	2. Name and Addre	ess of Facility	2222-		NSIN	AVE.,NW		
23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	In ations , at caused the dea the caus, on , ach line. a.	th. Do not ent	er the mode of dyi	ng, such as c				Approximate Interval Between Onset and Death		
resulting in death) Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect b. Respira Due to (or as a consect C. Due to (or as a consect d	atory uence of:	Failur∈							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aideath 3□	Ectopic pregnand Other (specify)	су			Date of deliver	ery Day Year		
Part II. Other significant conditions co	ontributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.		obacco use co Yes 2 ☐ No		he cause of death?		
					24a. Was autoj perfo 1 □ Yes			opsy findings available impletion of cause of		
ILI Ies ZIXIII	Hospital: 1 X Inpatient 2 □		IL 3 DOW	ner: 4□ Nurs	of Death <i>(Check only of</i> sing Home 5 ☐ Resi		Other (Specia	fy)		
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	ryat k? lYes 2.⊡N		Describe how injury occurred				
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	iome, farm, str ify)	eet, factory, office		28f. Location (. City or To		nber or Rur	al Route Number,		

29d. Date signed (Month, Day, Year)

20850

8/24/2009

Baltimore, Maryland 21215-0036 Brick/Stone Mason Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gerald Abraham Barnhart Grace Viola Wells ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald L. Barnhart - Brother 3721 Ivory Road Glenelg,MD 21737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 又 Cremation 3 ☐ Removal from State Smithsburg Crematory 08-28-2009 Smithsburg, Maryland 4 ☐ Dopation 5 ☐ Other (Specify) 22. Name and Address of Facility Osborne Funeral Home, P.A.
425 S.Conococheague St. Williamsport, MD 21795 21. Signature of Funeral 425 S.Conococheague St. Tim 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a Materios clarki Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusito (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) P.0. 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{ Residence} \) 6 \(\text{Other} \) Other (Specify) 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ BOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number Has 25, 2009 1)0-1062 19,011 orchard terme Rd. Hasas foun, M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WH 2+1 111 MI Edw27-d Year) 32. Registrar's Signature 31. Date filed (Month, Day, State AUG 27 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 13 u Year Physician Maurice McPherson Barnhart 0800 M 5 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner ll West Baltimore Street Washington Apt.1112 Hagerstown If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F 71 214-34-2233 Director Oct.17,1937 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, If a Medical Examing traumatic avent, If a Medical Examing traumatic avent, If a Medical Examing to restrict the medical Examing the medified at once. 1XYes 2 □ No Director Maryland Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ll West Baltimore Steet Apt.1112 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No 1957—

If Yes, Give Year or Dates: 1962 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. \$ Specify: 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 10 AM Margaret Anne Bennett 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 22705 Jefferson Blvd. Smithsburg Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. August Day 26ar) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 1934 Country, Pennsylvania 1 □ M 2 X F Director 193-28-0700 74 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits show an "natural", or Items 23a or 28a-f shov Medical Examiner must be notified at Pennsylvania Franklin Waynesboro 1 ☐ Yes X☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9330 Gap Road 17268 USA · death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes À No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: WHITE ₩idowed 4 Divorced ģ Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Dog groomer Kenne1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Morinier Pages 1 and 2 should other traumatic ပ္ Mildred Seiple 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 is any Injury or other traconce. Cynthia Nolan (Daughter) 22705 Jefferson Blvd., Smithsburg, MD., 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Smithsburg Crematory 8/25/2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Final T. Lochstampfor 22. Name and Address of Facility Lochstampfor Funeral Home, Inc. M-00849 48 S. Church St., Waynesboro, PA 17268 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) brown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 X No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s autopsy 1 Yes 2 L or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After To the Hospina. ... within 24 hours after death. To the Funeral Director: Aftrownletely filled in by the fur 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ML 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ĆH-1∆ State

State Registrar 31. Date filed (Month

DHMH 17 Rev 1/2001

32. Registrar's Signature

			For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F			giene Reg. No. 0 B S	28925
			1. Decedent's Name (First, Middle,	Last)				2. Date of Dea		3. Time of Death
	Physici /Medio		Learv	Bryant				Month 08	18 200	9 6:00A M
	Examir		4a. Facility Name (If not institution,		er)	4b. City, Town, or	r Location of De	eath	4c. County of	Death
			10110 New Hamp			Silver			Montg	
	Funeral		,	6. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last birthday)	Months Days	If Under 24 H	in. (Month, Da	v, Year)	Birthplace (State or Foreign Country)
	Director		245-54-2079 Usual Residence of Decedent		88 Yrs.			05/19/	1921	NC
	yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mar 9-f st	tor	MD Montgo	mery	Silver S	pring				1 ▼ Yes 2 No
	ith the Marylan or 28e-f show is notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?
	23a c		10110 New Hamps	hire Ave.	#209	20903			USA	
	tams tams	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		American Indian, White, etc.
36	s afte	by Fu	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes 2 🖺 No	Specify:		Specify:	D11-
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show he Medical Evaminer must be notified at	ed b	15. Decedent'	Year or Date		edent's Usual Occup	ation		16b. Kind of Busin	B1ack
15	in 72 n "na Aedic	Completed	(Specify only highest	grade completed)	(Give	e kind of work done of DO NOT use retired	durina most of v	working	TOO. THING OF BUSIN	iosams astry
212	filed with! Hygiene. other than ent, the M	mo	Elementary/Secondary (0-12) 6th grade	College (1-4	'	neer			Charles	E. Smith Mgmt.
br	e file othe vent,	Bec	17. Father's Name (First, Middle, L	ast)			18. Mother's N	Name (First, Middle,	Maiden Sumame)	
/lai	Menta Menta Mrked	2	Henry Bryant				Pear1	Thorne		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. item 27 Is marked other than "natural", or Itams 23a or 28e-1 shov other traumatic event, the Medical Examinar must be notilited at		19a. Informant's Name/Relationsh	ip (Type, Print)				Rural Route Numbe		
	Health Health tem 27		Hanna J. Bryant	:/Wife			shire A	Ave. #209		
Baltimore,		1 8	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from Sta	20b. Place of Disp cemetery, cre	osition (Name of ematory or other plac	ce) 8/1	Date 25/2009	20c. Location - Ci	ty or Town, State
Ë	tant:		`4 ☐ Donation 5 ☐ Other (Sp			Heaven Ce	em.		Silver S	
Bal	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Fungral Service L	1 4 //	162077			Marshall's		Home
	202 0		23a. Parti. Enter the disease, or o	1701/1000				ashington		Approximate
			shock, or heart failure. List of	only one cause on eac	h line.	iter the mode of dyn	ig, such as care	nac or respiratory ar	1631,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	W	nemic Cardio	myopathy				2 years
	Examiner				as a consequence of):	Diagnas				20 years
		e	Sequentially list conditions, if any landing to immadiate		onary Artery as a consequence of:	Disease				20 years
)	uted d ansit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events	c						
oʻ	be executed slcian and buriat-transit	Exa	resulting in death) Last		as a consequence of):					
8760,	a y	dical	1	d						
9	leath certifica attending ph I for use as tl	Med	IF FEMALE:	112-2				-		
Вох	ath ce ttendi	Physician/Me	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetal death 3	Ectopic pregnancy	/		23d. Date of Month	
0	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnan 9☐Unknow		Other (specify)				,
Δ.	requires that the de leen signed by the a hould be detached t		Part II. Other significant condition	ns contributing to deat	h but not resulting in the	Inderlying cause giv	en in Part I	23e. Did to	obacco use contrib	ute to the cause of death?
ds,	sign d be	d by	Diabetes Mell			and any my data of gri		1 🗆 1	fes 2⊠No 3	☐ Probably 4 ☐Unknown
Sor	> 0 0	ete						240 1860	24h W	va autonov findinas available
Record	has has	Completed							rmed? prid	ore autopsy findings available or to completion of cause of ath?
B	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical				00 Pt	1 Yes		Yes 2X No
Vital		To Be	examiner?	Hospital: 1 □ Inp	atient 2 ER/Outpatie	nt 3 DOA Oth	-	Death (Check only o		(Conside)
of			27. Manner of Death	28a. Date of	Injury 28b. Time of	of 28c. Injur	y at		now injury occurred	
lo	± 2 ₹ 2	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig		Day Year) Injury	Wor M 1 □	Yes 2 □ No			
Division	or Attendate death Director:	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determine	ned 286. Place of	Injury - At home, farm, st , etc. (Specify)	reet, factory, office		28f. Location (S		or Rural Route Number,
	rs after rel Dire	Cer								
	To the Hospitel o within 24 hours aft To the Funerel Di completely filled in	edicai			est of my knowledge, dea s of examination and/or in r stated.					
	To th Within To th	Me	29b. Signature and title of certifier	, 7		29c. Licens			29d. Date signed (
2			ha & M	1. Alex	error . M	D250	บชบ	F	August 20	, 2009
-			30. Name and address of person v	no completed cause	of death (Item 23a) (Type	, Print)				
_			Frank N. Gravin	o, MD 1031	3 Georgia A	ve. Suite	307 Si	lver Spri	ng MD 20	902
	Sta	3	31. Date filed (Month, Day, Year)	3. Reg	istrar's Signature	, dell		•		
	Registr	ar	AUG 24 2	UUY Clerk	u p. ya	Color .				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death AUGUST 18,2009 **Physician** MARION LUCILLE BOYD 8:35 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY Silver Spring 11536 February Circle If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 12,1929 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2√2 F ALabama 80 215-44-3692 Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination must be notlified at MD Montgomery Silver Spring 1 ☐Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 11536 February Circle, #203 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify Specify: Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker h and Mental Hygie 7 is marked other the 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Windom H. Young Nancy J. Jackson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 11542 Fébruary Circle, #302, Silver Spring,MD 20904 Joann M. Charles (Daughter) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S permit. Page Department of Important: If any injury or once. Maryland Veteran Cem. 9/1/09 5 ☐ Other (Specify) Cheltenham, MD 4 ☐ Donation 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licen 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death enter the mode of dying, such as cardiac or respiratory a rest 23a. Part 1. Enter the disease or complicat shock, or heart failure. List only on Immediate Cause (Final 10-**Physician** monar disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consec Hospital or Attending Physician: The law requires that the death certificate be executed Exami -tran and Due to (or as a consequence of) physician a Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) Division of Vital Records, P.O. cate has been signed by the page 2 should be detached 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 🗌 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1□Yes 2□Klo Other: 4 ☐ Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 5 Residence 6 ☐ Other (Specify, 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending ours after death. nera! Director: Af filled in by the fur 1 □Yes 2 □No investigation 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Hornicide 24 hours after 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated To the within 2 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) me a

Registrar DHMH 17 Rev 1/2001

State

Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Allene B. BAUM 10:07 PM August 23, 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 15, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 79 Yrs. 1 □ M 2 🗙 F Months Days Hours Min 577-40-8602 1929 Washington, DC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 □Yes 2 No Rockville Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? United States 20852 5809 Nicholson Lane #103 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Specify: white 1 ☐Yes 2 No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Morris Bildman Rose Shapiro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5809 Nicholson Lane #103, Rockville, MD 20852 Stanley Baum, Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State B'nai Israel Cemetery 08/25/09 Oxon Hill, MD 4 Donation 5 ☐ Other (Specify) Funeral Service Licensee 401008 Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure disease or condition resulting in death) Due to (or as a consequence of): Emphysema (COPD) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 5 Other (specify) 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Liver Failure 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 □ Yes 2 🗘 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No Metastatic Cancer <u>Kidney Failure</u> 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide

Physician /Medical **Examiner** Examine

Physician

Examiner

Funeral

Director

ral", or items 23a or 28a-f shov Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Experient must any injury or other traumatic event, the Medical Experient must once.

Baltimore, Maryland 21215-0036

Directo

by Funeral

Completed

Be

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/Medical

physician and the burial-transi attending p ate has been signed by the page 2 should be detached

e Hospital or Attendir 124 hours after death. e Funeral Director: Al

Division of Vital Records, P.O. Box 68760,

8/23/09 2207 (Pm)

Physician/Medical Completed by Be Certification: To Medical

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D66066

28f. Location (Street and Number or Rural Route Number, City or Town, State)

20814

8600 Old Georgetown Rd., Bethesda, MD

4 Homicide

State Registrar

31. Date filed (Month, Day, Year, AUG 25

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD Wong

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 24

			1 - For State Registrar	State of	Marylan	•	artmen rtificat			and M		giene Reg. No. 🤈	009	28928			
	Physici /Medi		1. Decedent's Name (First, Middle Evaristo	Baez							2. Date of Dea		9 Year	3. Time of Death 1930 M			
-	Examir		4a. Facility Name (If not institution Holy Cross 5. Social Security Number	t 4 k - 4 k - 4 k		lve	Location o	ring				ery place (State or Foreign					
	Funeral Director		580-36-0939 Usual Residence of Decedent	6. Sex 1 X M 2 ☐ F	Age (In yrs. I	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da Oct. 28	, Year)	Coui	rto Rico			
	e Maryland 3a-f show iffied at	ctor	10a. State 10b. County	omery		y, Town or Lo lver		ng					1	1 ☐ Yes 2 No			
	th with the 23a or 28	al Director	10e. Street and Number 11550 Stewar	t Lane #2	202		10f. Zip	Code 0904	1			10g. Citizen USA	of What Cou	ntry?			
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? • No		1 XYes	2□No			cify Yes or No- Rican, etc.)		Race - Americ Black, White, ecify: W				
21215-(d within 72 h giene. er than "natu i the Medical	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1-4e	or 5+)		dent's Usua kind of wo DO NOT us echal	rk done d se retired	ation <i>during m</i> os)	t of workir	ng		f Business/In				
land	12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "I traumatic event, The Mac	To Be (17. Father's Name (First, Middle, Delfin Mont								(First, Middle, a Baez		na <i>me)</i>				
, Mar	1 and 2 sho Health and I em 27 Is ma other trauma		19a. Informant's Name/Relations Guillermina B											code)20904 ing,Md			
Baltimore, Maryland 2121	permit. Pages 1 a Department of He Important: If item any Injury or othe	100	20a. Method of Disposition 1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (\$)		ate Ma	lace of Dispo emetery, crer yland	natory or o Nat	ther place T	Mem.	8/24	/2009		rel,M	d.			
Balt	permit. Depart Import any Inj		21. Signatur Funeral Service	Lice see		P 9	HIMS IN 241		§R⊞Ni umbi	ALDI a Bl	FUNE vd.Si	RAL SI Lver	ERVIC Sprin	E,P.A. g,Md20910			
E	Physician //Medical Examiner the private transit	ical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Aspi Due to (or b. Due to (or c. Coro	ratio as a consequ e Str as a consequ nary as a consequ	uence of): oke uence of): Arter			se					Interval Between Onset and Death			
O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d.	Date of deliv Month	ery Day Year				
rds, P.	quires that t in signed by uld be detac	Completed by Phy	þ	þ	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying						,					he cause of death?
E	The ate h								-		24a. Was autop perfor 1 🗆 Yes		lb. Were auto prior to co death? 1 □ Yes	opsy findings available mpletion of cause of			
		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo	Hospital:	atient 2	EB/Outnatier		Othe	er:		(Check only one 5 ☐ Residence		Othor (Case)	6.0			
n of	une Ine	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could r	28a. Date of (Month, ation lot be 28a Place of	Injury <i>Day,</i> Ye <i>ar)</i>	28b. Time of Injury	M 2	8c. Injury Work 1 🗆 `		No 2	28d. Describe h	ow injury occ	curred	al Route Number,			
Div	spital or A nours after neral Dired filled in by		4 Homicide determine 29a. Certifier 1 **Certifyin**	g Physician: To the be	, etc. (Specify	v) 			ne, date ar		City or Toʻv	n, State)					
	To the Hospital or Attendi Within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical	(Check only 2 Medical 29b. Signature and title of certifier	Examiner: On the basi and manner	is of examina	tion and/or in	vestigation	, in my o	pinion, dea	ath occurre	ed at the time,	date and place 29d. Date sig	ned (Month,	o the cause(s)			
			30. Name and address of person Nabila Khan	who completed cause of M.D. 150	of death (Item 00 For	est (Print) Glen	Roa	d Si	lvei	c Spri	ng,Md	1.2091	0			
	Sta Registr		31. Date filed (Month, Day, Year) AUG 25 2	1009 Senter	istrar's Signa	par	No.										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Richard Frederick Beyer 28,2009 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CITIZENS Homz URSING 8. Date of Birth (Month, Day, Year 02-11-1932 last birthday) 77 **Funeral** Maryland 215-28-1665 1**X** M 2□F Days Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 Commerce Street Suite 201 21078 United States of America Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1951 – 54 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Pilot Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be August Beyer Alerthia Sims 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27078 19a. Informant's Name/Relationship (Type. Print) Virginia C. Beyer (WIFE) 700 Commerce St., Suite 201, Havre de Grace, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State RA Ferris & Co., Inc. 08/30/2009 West Chester, Pennsylvania 4 Donation 5 Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 21. Signature of Funeral S Washington St. Havre de Grace Maryland e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause an each of the death. 23a. Part1. Enter the shock, or hear Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical us to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 2 No 1 TYes 3 Probably 4 Unknown Be Completed KICKARD H 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 □ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date-signed (Month, Day, Year)

Registrar

State

30. Name and address of

32

gistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year James L. Brown, IV August 24 2009 0430 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Easton Memorial Hospital Talbut 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day) **Funeral** 1 M 2 □ F Year) 126-22-6474 Days Hours Min. Months 81 June 8, 1928 Director NJ Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evaminer must be notified at Director MD Elkton Cecil 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 S. Shore Rd. 21921 USA Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? 1 ☑ Yes 2 ☐ No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 ☑No If Yes, Give Year or Dates: Specify: Completed by Specify: 3 Widowed 4 □ Divorced 19405 White Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Western Electric Pages 1 and 2 should be filed venent of Health and Mental Hygicant: If item 27 is marked other? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James L. Brown, III ပ Melva Gesner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Melchior/Daughter 29875 Dogwood Rd., Greensboro, MD 21639 Injury or other Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co., Inc. West Chester, PA August 26, 2009 Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home, 259 E. Main St., Elkton, MD 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician evonav disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to interest cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the aftending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed' certificate 2 40 1 □ Yes 2. No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Tes 2 → Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

AUG 27 2009

841VA

Brown, James

32. Registrar's Signature

DHMH 17 Rev 1/2001

knews

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		For State Registrar	State of M		id / Dep		Health a	nd Mental Hy		2009	28931		
Physicia Medic		1. Decedent's Name (First, Middle, Last) Helen Alberta Cochran						2. Date of De Month August	Day	2009 2009	3. Time of Death 1:10 P M		
Examin	er	4a. Facility Name (if not institution, gi	•			4b. City, Town, o	or Location of OWSON	Death	4c. (County of Death Baltimo			
Funeral Director		5. Social Security Number 220-80-8847 Usual Residence of Decedent	Sex 7. Ag 1 ☐ M 2 🖾 F	e (In yrs. I	ast birthday) Yrs.) If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Date of Bi Min. (Month, Da June 1	th 17. Yea <i>r)</i> 8, 19.	9. Birth Cour 15 Vire	pplace (State or Foreign ntry) sinia		
ter or amin	rector	10a. State 10b. County 10c. City, Town of Maryland Howard Colu									10d. Inside City Limits 1 ☐ Yes 2 ☒ No		
	Funeral Director	10e. Street and Number 6336 Cedar Lane		10f. Zip Code	21044		10g. Citiz	en of What Cou USA	intry?				
	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes, Give Year or Dates.			S. 13.	. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🎛 No	an, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)		4. Race - Americ Black, White, Specify: Whj	etc.		
ithin 72 hour ene. r than "natu the Medical	Completed	(Specify only highest grade completed)				edent's Usual Occu e kind of work done DO NOT use retired Iomemaker	duning most of	of working	16b. Kind of Business Industry Own Home				
id be filed w Mental Hygi arked other atic event, t	To Be	17. Father's Name (First, Middle, Las Edwin Carson Je					Name (First, Middle, Maiden Surname) Virginia Havener						
nd 2 shoule eaith and h m 27 is ma		19a. Informant's Name/Relationship Joan Collins /		Too. 5	8756	Teresa I		or Rural Route Number aurel, MD	2072	3			
iit. Page 1 and minute of heart of heart of heart of heart if its night or of nighty or of heart.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	t Linco	position (Name of ematory or other plate) oln Cemeter	y 8	Date 3/26/2009	20c. Location - City or Town, State Brentwood, Maryland						
perm Depa Impo any i		- //	ZAY Rogers		G		neral		. Hya	9 Balti ttsville	more Avenue e, MD 20781		
Physician/ Medical Examiner		23a. Part Y. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Long licenters of dumbles Due to (or as a consequence of):											
cuted ind transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.											
icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of): d											
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. On the Funeral Director, After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1								very Day Year		
quires that en signed to	ted by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco us 1 Yes 2								use contribute to the cause of death? No 3 Probably 4 Unknown			
The law re cate has be page 2 sho	Completed	CAD CHF							24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings a prior to completion of odeath? 1 Yes 2 No 24b. Were autopsy findings a prior to completion of odeath? 1 Yes 2 No				
ysician: is certifi director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 🗆	ER/Outpatio	26. F		(Check only one)	g Home 5 ☐ Residence 6 🗶 Other (Specify) Cilchist				
ending Phy eath. or: After thi he funeral o		27. Manner of Death 1 Natural 5 Pending (Month, Day, Year) 28b. Time of injury at work? 1 Noticide 6 Could not be 28c. Injury at work? 1 Yes 2 No								occurred			
pital or At ours after o eral Direci	Medical Certificate:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Ru City or Town, State)											
the Hos thin 24 h the Fun	Medi										ause(s) and manner stated tated.		
		29b. Signature and title of certifier Mani Land	RIY	ense number 29d. Date signed (Month, Day, Year) Hygust 21, 2001									
25		30. Name and address of person who was Grant	GTOI N	. (h	arks (on, N	10 2120	(
Stat Registra	te ar	31. Date filed (Month, Day, Year) AUG 2 6 2009	32. Registr	ar's Signat	ture								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1:05 AM Jacqueline Lewis Clark /Medical 2009 August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3105 Hillside Avenue Cheverly Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Darflington Hts, Months Days Hours Min. 1 □ M 2 🖫 F 080-26-6704 Director 79 06/16/1930 Virgīnia Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at MD Prince George's Director Cheverly 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3105 Hillside Avenue U.S.A. 20785 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after to partment of Health and Mental Hygiene. In propriant: If item 27 is marked other than "natural", or ite may injury or other traumatic event, the Medical Evancine of se. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Dept. of State Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary (Federal Government) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lou Edna Carrington William Joe Lewis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3105 Hillside Avenue Arthur N. Clark/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Bladensburg, MD Fort Lincoln Cem. 8/29/2009 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHenry S. Washington & Sons Co., Inc., 4925 N.H. Burroughs Ave., N.E any 1a4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pancreatic Cancer 6 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 ▼ No Day Year 5 Other (specify) iis certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 🔀 No 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No after death filled in by the 6 ☐ Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PHYSICIAN

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registraris Signature

Sydney Morss Dy, M.D.

31. Date filed (Month, Day,

AUG 2 6 2009

D53590

624 North Broadway, Baltimore, Maryland

			For State Registrar	State of Mar		artment of F rtificate of	neaith and Me Death	entai mygie Reg.	01110	28931
	Dharis		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Clara Virgin		ns			tugust	20, 200°	7 5828 PM
may.	Examin		4a. Facility Name (If not institution, gir			4b. City, Town, o	r Location of Death		4c. County of Deat	h
14.75			Doctor's Commun				Lanham		Prince	George
	Funeral			Sex 7. Age 1 □ M 2 🖾 F	(In yrs. last birthday Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		hplace (State or Foreign untry)
	Director		216-22-1052 Usual Residence of Decedent		91 115.		D	ec. 30,	1917 M	aryland
	land ow		10a. State 10b. County	1.	10c. City, Town or L	ocation				10d. Inside City Limits
	Mary If sh	į	Maryland Princ	e George		ī	Laurel			1⊠Yes 2□No
	r 288	Director	10e. Street and Number	8-		10f. Zip Code	<u> </u>	10g.	Citizen of What Co	untry?
	23a o		12701 Duckettsto	wn Road			20708		United	States
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	Hispanic Origin? (Spec an, Mexican, Puerto R	cify Yes or No-	14. Race - Ame Black, White	
98	be filed within 72 hours after death with the Maryland tital Hygiene. do other than "natural", or items 23a or 28a-f show event, i'm fluidical Exa, i'm er instite i cufffed at	Z.	1 Never Married 2 🔀 Married	1 □Yes 2 📆 No If Yes, Give		1 ☐ Yes 2 🖾 No		ioun, otor,	Specify: Af	
Maryland 21215-0036	ural",	d by	3 Widowed 4 Divorced	Year or Dates:	10.0			401	Am	nerican
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12	e filed within al Hygiene. I other than " vent, tre me	Ę.	Elementary/Secondary (0-12)	College (1-4or 5+)	1		Technicia	1	Govern	ment
d 2	filed Hygi Sther ent, t		17. Father's Name (First, Middle, Las	 ')	1		18. Mother's Name			
an	id be ental ked o	To Be	Thomas A	sbury Hall,	Sr.		Α,	gnes Duck	rett	
ary	2 should be and Menta is marked aumatic ev	-	19a. Informant's Name/Relationship			ing Address (Street	and Number or Rural			Zip Code)
	1 and 2 Health a em 27 is		Helen C. Smith/	/Sister	13226	-11th Str	reet Bowi	e, Maryla	and 20715	
<u>e</u>			20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place ngton	Septen 29,200	ber 200	c. Location - City or	Town, State
<u><u>E</u></u>	permit. Pages Department of Important: If its any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Ponation 5 ☐ Other (Speci		∥Nationa	l Cemeter	·v	IAI	lington,	Virginia
alt	permit. Depart Import any inj once.		21. Signa use of Fix eral Sayvice Line	n ee	2	2. Name and Addre	ess of Facility Stev	vart Fune	eral Home	, Inc.
ш_	70 E # 9		MAN	Mull	7 4	OUI Benni	ing Rd. NE	Washing	gton, DC	20019
			23a. Part 1 Enter the disease, or con shock or heart failure. List only	plications that caused the	ne death. Do not er	ter the mode of dyi	ng, such as cardiac or	respiratory arrest,		Approximate Interval Between
Lay F	Physician		Immediate in suffinal disease or contion	- a	Sepsis					Onset and Death
and the	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
	LAGIIIIICI	<u></u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or so a	consequence of):					
	ted nsit	in in	Cause (Disease or injury	Due to (or as a	consequence or).				-	
	execu n and al-trai	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):					
68760,	Attending Physician: The law requires that the death certificate be executed refeath. refeath. estor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit			. d						
89	tificat g phy as the	edical								
Box	h cer endin use	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		☐ Ectopic pregnand	24		23d. Date of de	livery
o O	ed for	sicis	in the past 12 months? 1 ☐ Yes 2 🎛 No	4 ☐ Pregnant at ti		Other (specify)	-y		Month	Day Year
P.	w requires that the death cer been signed by the attendin should be detached for use	Physician/IV	9 ☐ Unknown					On Billi		
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oro.	requi	Completed	1681/1	18 sect	100,1000	34 311	CCCCON	1 ☐ Yes	2 100 3	TODADIY 4 OTIKITOWIT
Sec.	e 2 si	nple.						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
a E	icate icate , pag							performed 1 ☐ Yes 2 🔀		2 □ No
Division of Vital Records,	siciar certil recto	Be	25. Was case referred to medical examiner?	Hospital:		ont 3 🗆 DOA Oth	26. Place of Death	<u> </u>		
o t	Phy r this ral di	1: 10	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	t 2 ☐ ER/Outpatie	of 28c, Inju	rv at 2	le 5 ☐ Residence Bd. Describe how i	e 6 Other (Spe	cify)
on .	ding th. Afte fune	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, n	Year) Injury	Wor	rk̃?]Yes 2 □ No		. ,	
/isi	Atter r dea ector by the	iji	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury	y - At home, farm, st	reet, factory, office	2	Bf. Location (Stree	at and Number or Ru	ural Route Number,
<u> </u>	al or s afte al Dir ed in	Certification:	4 - Horricide	building, etc.	(Specify)			City or Town, S	nate)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s			hysician: To the best of miner: On the basis of e						
	the H nin 24 the F	Medical	one)	and manner state						
	7 with 00 con	2	29b. Signature and title of certifier	() (.	OP	29c. Licens	se number	29d.	Date signed (Mont	n, Day, Year)
			10101	31	T	100	11660		5-21-	
2	-8		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type	X (~	1124	Boar	, e MI) 20)/
	Sta		31. Date filed (Month, Day, Year) AUG 2 7 2009	32. Registrar	s Signature	,				
DHM	Registr IH 17 Rev 1/2		MUG & (EUU)	commer p.	7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		For State	State	of Marylan		artment of H <i>rtificate of L</i>					the construction of the construction
		Registrar 1. Decedent's Name (First, Midd	die. Last)		Cei	lineale or i	Jean	2. Date of Dea	Reg. No.	3.7	Time of Death
Physicia	_	Gladys May Ca						Month	Day		:15 AM
/Medic Examin		4a. Facility Name (If not instituti		number)		4b. City, Town, or	Location of Deat		4c. County	A	
		Washington Co	unty Hos	oital		Hagers				ington	
Funeral Director		5. Social Security Number 192–32–7755	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 2,	1937	9. Birthplace (Country) Pennsy	State or Foreign lvania
nd v		Usual Residence of Decedent		10- 0	ty, Town or Lo					10d In	side City Limits
with the Maryland a or 28a-f show	5	10a. State 10b. Count	•								□Yes 2⊠No
the N	Director	Maryland Wash:	ington	па	gersto	WII 10f. Zip Code			10g. Citizen of \	What Country?	
th with	Ö	17743 Virginia	Ave.				740			SA	
death	Funeral	11. Marital Status	12. Was D	ecedent Ever in U. Forces?	.S. 13.	Nas Decedent of H If Yes, specify Cuba	ispanic Origin? (S	Specify Yes or No-		ce - American Ind	dian,
flied within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ent, the Wedical Examination coulffied at	by Fu	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 XX ivorce	arried 1 □Ye If Yes,	s 2 🔯 No		1 □Yes 2 X No	Specify:	to filoan, cto.)	Specify	,	
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iled w Hygie ther th	S	17. Father's Name (First, Middle	a Last)		Paint	: Prepare		ne (First, Middle,		Manufact	uring
ld be f lental ked o	To Be	Chester Arthur		na		;		agdelene		•	
shoul and M s mar rumat	-	19a. Informant's Name/Relation		-9	19b. Mailir	ng Address (Street					a)
and 2 ealth n 27 i		Brian Carbaugh	- Son		1774	3 Virgin	ia Ave.	Hagerst			
ges 1 t of H if iter or oth		20a. Method of Disposition 1XX surial 2 □ Cremation	3 □ Removal fro		Place of Dispo cemetery, crer	sition (Name of natory or other plac	e)	Date	20c. Location -	- City or Town, S	State
it. Par rtmen rtant: njury		4 □ Donation 5 □ Other	(Specify)			Mem. Par		3-2009			Maryland
permi Dapa Impo amy Ir		21. Signature of Funeral Service	a Livensea		42	2. Name and Address 25 S.Conoc	ss of Facility Osl cocheague	oorne Fu e St. W	neral Ho illiams _l	ome,P.A. port,MD	21795
		23a. Part1. Enter e disease, shock, or hart failure. Lis	or complications the	at caused the deat	h. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory ar	rest,	Inter	roximate val Between
Physician		Immediate Cause (Final disease or condition	_ a	aro	Cor	espo	afo	ry /-	ailu	re ons	et and Death
/Medical Examiner		resulting in death)	Due	of wan	uence of):	Cell	Carc'	noma	07/26	1-/10	Francisco
	e	Sequentially list conditions, if any, leading to immediate	b. Due	to (or as a conseq					100.	Lang	J Tes Pore
cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	5 .								
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icate b physic the b	dical		d								
nding use as	a	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		_			23d. Da	ite of delivery	
death	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pr	ve birth 2 □ Feta regnant at time of o nknown		☐ Ectopic pregnanc ☐ Other (specify) _	у		Me	onth Day	Year
lat the d by the etache	Physician/M	9 Unknown			internal and a second		er in Death	220 Did to	phoses use sen	tribute to the cau	use of death?
signed by the d	þ	Part II. Other significant condi	tions contributing to		uiting in the u	ngeriying cause giv	en in Part I.	23e. Did 10	_		4 ☐ Unknown
w requ	letec	Clin	ori'	dues	true	1:11	Portono	24a. Was	•	Were autopsy fi	
The lar te has age 2	Completed					1.	Disee	autop	sy med?	prior to complet death?	ion of cause of
ian: artifica ctor, p	BeC	25. Was case referred to medic	al				26. Place of De	1 ☐ Yes ath (Check only o	/-	1 □ Yes 2 N	150
hysic his ce Il direc		examiner? 1 ☐ Yes 2 ☐ No		atient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing I	Home 5 ☐ Resid	lence 6 □ Otl	her (Specify)	
ding P. I. After t	ion:	27. Manner of Death 1	ling (N	ate of Injury Nonth, Day, Year)	28b. Time of Injury	Worl	< ?	28d. Describe h	ow injury occur	red	
Attence: death	ficat	3 ☐ Suicide 6 ☐ Could	minod 200. Pla	ace of Injury - At h	ome, farm, str		Yes 2 □ No	28f. Location (S	Street and Numi	ber or Rural Rou	ite Number,
tal or /	Certification: To	4 ☐ Homicide deter	bu bu	ilding, etc. (<i>Speci</i> i	fy)			City or Tow	n, State)		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certify (Check only one)	ring Physician: To al Examiner: On th and m	the best of my kno e basis of examina nanner stated.	owledge, deat ation and/or in	h occurred at the til vestigation, in my o	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and m date and place,	and due to the	cause(s)
To the within To the compl	Me	29b. Signature and title of certif	ier			29c. Licens	e number		29d. Date signe	ed (Month, Day,	Year)
		> UA Dan	Ca u	r D		103	3549		8-5	-6.0	5
5H-4	!	30. Name and address of person	n who completed c	ause of death (Iter	n 23a) (Type,	Print)	2 OF.	41 07	- HASE	RSTOR	Year) 5 217
Stat Registra		31. Date filed (Month, Day, Yea	2 2000 32	2. Registrar's Signa	ature	£					200

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		1 - State Registrar				Cei	rtificate	of L	Death	7		Reg. N	0201	19	28935
sicia edica		1. Decedent's Name Waltor		ell Childs	5						2. Date of De Month August	Da		Year 9	3. Time of Death 10:14 P M
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ral tor		5. Social Security Nu 215–12–9	755	6. Sex 1 XX M 2□ F	7. Age (In yrs. 87	last birthday) Yrs.	If Under Months	1 Year Days	If Unde Hours	er 24 Hrs. Min.	8. Date of Bir (Month, Da Sept. 1	th ly, Year 3,	1921	Coun	elace (State or Foreign aryland
н .		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Lo	cation							11	0d. Inside City Limits
come	Director	Maryland		Arundel					olis			-10 0			1 □Yes 2/□No
uar na u	ral Dir	10e. Street and Num 1505 Bro		Place, #	301		10f. Zip		2140	9		10g. C	itizen of WI	S.A.	-
	Funeral	11. Marital Status		Armed Fo		S. 13.	Was Decede If Yes, speci	ent of Hi ify Cuba	spanic C n, Mexica	Prigin? (Spa an, Puerto	ecify Yes or No Rican, etc.)	-		- Americ , White, e	an Indian, etc.
	2	1 ☐ Never Marrie 3🌠 Widowed 4				I	1∐Yes 2	OX No	Specif	iy:			Specify:	Wh	nite
ESITOR .	Completed	(Speci	15. Deceden	it's Education st grade completed)		(Give	dent's Usua kind of work DO NOT use	k done d	lurina ma	st of worki	ing	16b. I	Kind of Bus	iness/Ind	dustry
N. N.	gmo	Elementary/Secor	ndary (0-12)	College (me, i	Pater	,		r			U.S.	Nav	<i>7</i> y
Svent,	BeC	17. Father's Name ('					e (First, Middle,		n Surname)	
	9	Walton				T					le Hurst				
		19a. Informant's Na Mark B.	Childs	: ' ''		1602	St. N	Marg	aret		al Route Numb pad Anr	napo	olis,	MD	21409
n		20a. Method of Disp 1 ☐ Burial 2X 4 ☐ Donation	Cremation	3 ☐ Removal from	State I	lace of Dispo emetery, cren ltimore					Date /2009		Location - C timor	•	_{wn, State} Iaryland
once.		21. Signature of Fur	neral Service	Incenseey /))	22	2. Name and	Addres	s of Faci	lity Joh	nn M. Ta	aylo	or Fun	eral	
		23a. Part 1. Short the	e disease, or	complications that conly one cause on contractions	caused the death						T. (2)	•	ипарс	112	Approximate Interval Between
an		Immediate Cause (I disease or condition	Final	a. A		TENO	C .S .	Ses.	اب	2					Onset and Death
cal ier		resulting in death)		Due to	(or as a consequ	uence of):	D w	8 UJA#	M	Unci	andia	0.	C	bo.	6 wks
	iner.	Sequentially list con if any, leading to imm cause. Enter Under Cause (Disease or in	ditions, nediate lying	b. Due to	(or as a consequ	uence of):	,	D		700	ardia	W [y are	(W)	Ø.55. K
	Examiner	that initiated events resulting in death) L		c. Due to	or as a consequ	uence of):	tery	V	521	AGE				-	
	Medical			d. D	ENEN	TIA									
	Med	IF FEMALE:													
	Be Completed by Physician/	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1 ☐ Live	tcome of pregna birth 2□ Fetal nant at time of d nown	Ideath 3□	Ectopic pro			-			23d. Date Mon		ery Day Year
i	y P	Part II. Other signifi	cant conditie	ons contributing to d	eath but not resu	ulting in the ur	nderlying ca	use give	n in Part	: I.	23e. Did to	obacco	use contrit	oute to th	ne cause of death?
	D E	Hyperly	piden	ria, De	245510	on 1	ros	eps	بح		1 🗆 1	es 2	2 □ No 3	B Prob	ably 4 Unknown
	ombie										24a. Was autop perfo 1 □ Yes		pr de	ere autorior to coreath?	psy findings available mpletion of cause of
	e R	25. Was case referre	ed to medical						26. Plac	ce of Death	h (Check only o		0 11		2
		1 □ Yes 2			<u> </u>	ER/Outpatier		A Othe	r: 4□N	Nursing Ho	me 5 Hesi	dence	6 □Other	(Specify	y)
	ation:	27. Manner of Death 1 Matural 2 ☐ Accident	5 □ Pendin investi	9 '	of Injury oth, Day, Year)	28b. Time of Injury	M 28	Bc. Injury Work 1 □ Y	rat ? ′es 2 [ì	28d. Describe I	now inju	ury occurred	d	
	Medical Certification: 10	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could in determ	inod Zoe. Place	of Injury - At ho ing, etc. (Specify	me, farm, stre	eet, factory,	office			28f. Location (8 City or Tov	Street a vn, Stat	and Number te)	r or Rura	I Route Number,
	edical	29a. Certifier (Check only one)	1 Certifyir 2 Medical	ng Physician: To the Examiner: On the b and man	e best of my kno- pasis of examina- ner stated.	wledge, deatl tion and/or in	n occurred a vestigation,	at the tim in my op	ne, date a	and place, eath occur	and due to the red at the time,	cause(date ar	(s) and mar	nner as s	stated. the cause(s)
)	Ĭ	29b. Signature and t	itle of certifie	MO_					number	_		_	ate signed		
		30. Name and addre	ess of person	who completed cause	se of death (Item	23a) (Type, Mcclic	Print)	huy	Sk	-100	ANNA	Per	Lis,	MD	21401
State istra	2	30, Name and addre	UG 20	2009 32.5	egistrar's Signat	ture.	are	,						. =	
	_														

Registrar

			1 - For State Registrar		State of N	narylanu /	•	iriment of <i>tificate of</i>		id Mental F	Tygle: Reg.		20001
	Physici	an	1. Decedent's Name (st)					2. Date of Month		Day Year	3. Time of Death
	/Medi	cal	Eulalia Co			-1		# Ob T		Augus		3 2009	2:45 P M
,	Examir	ner	4a. Facility Name (If n					4b. City, Town, Bethe		Jeam		4c. County of Death	~ 17
	Funeral		5. Social Security Nun			Age (In yrs. last	birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of	Birth	Montgome 9. Birth	place (State or Foreign
	Director		155-01-33	19	□ M 2 🔀 F	95	Yrs.	Months Days	Hours	Min. 8. Date of (Month,	11, re	1913 Washi	ngton, D.C.
	land		Usual Residence of D 10a. State	Ob. County		10c. City, To	own or Loc	cation					10d. Inside City Limits
	Mary I-f sh	to	MD I	Montgome	ery	Bethe	esda						1 √Yes 2 No
	th the	Director	10e. Street and Numb					10f. Zip Code				Citizen of What Cour	,
	ath w	rai	8200 Wisco	onsin Av	· · · · · · · · · · · · · · · · · · ·			2081				nited Stat	
030	be filed within 72 hours after death with the Maryland nat Hygiene. ed other than "neturel", or flems 23a or 28s-f show event, the Medical Examinar must be porfiled at	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4		12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	₹ vo ≥3	1	Vas Decedent of Yes, specify Cul ☐ Yes 2√2 No		n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Americ Black, White, Specify: Asi	etc.
9500-61212	within 72 ho ene. than "netur he Medical	Completed	(Specify Elementary/Second	5. Decedent's Ed only highest gra lary (0-12)	ducation de completed) College (1-40	r 5+)	(Give I life. E	ent's Usual Occu kind of work done OO NOT use retire	pation during most of ed)	f working		. Kind of Business/In	dustry
	e filed within al Hygiene. other than '		12 17. Father's Name (Fi				Desig	mer	1			ostumes	
yland	d be fi	To Be	Gensaburo							Name (First, Mid elatta		,	
Mary	nd 2 shoullth and M 27 is merl r treumati	F	19a. Informant's Nam Lawrence I	e/Relationship (7	Type, Print)	l ntative	9b. Mailin	g Address (Stree Bethesda	tand Number of Metro	or Rural Route Nu Center # 4	mber, Ci 530	ty or Town, State, Zip	Code)
saltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: if item 27 is marked eny injury or other traumatic enge.		20a. Method of Dispos	sition Cremation 3 🗌	Removal from Stat	20h Place	of Dicnor	sition (Name of patory or other pla 1. Unive		ug. 18 2009	20c	shington, I	
Balt	permit. Departmimports eny inju		21. Signators of Fune	-		/M00969	22.	Name and Addr	ess of Facilit	olumbia		uary Serv MD 20706	ices, P.A.
			23a. Part1. Enter the shock, or heart t Immediate Cause (Fi	failure. List only	plications that caus one cause on each	ed the death. D	o not ente	or the mode of dy	ing, such as ca	rdiac or respirator	y arrest,		Approximate Interval Between Onset and Death
Ĭ	Physician /Medical		disease or condition resulting in death)	-	a. H9	as a consequence	ce of):						
	Examiner		Sequentially list cond	itions	b						_		
	ed sit	iner	Sequentially list cond if any, leading to imm cause. Enter Unicerly Cause (Disease or in that initiated events	ediate	Due to (or a	is a consequent	ce of):						
'n	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events resulting in death) Las	st	C. Due to (or a	s a consequenc	ce of):						
08/00	ate be hysicia he bur	edicai			. d.								
	ertifica ding pl		IF FEMALE:		20- W A								
.c. Box	ie law requires that the death cert has been signed by the attendin ge 2 should be detached for use	hysician/N	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	onths?		2 Fetal dea at time of death	ath 3□	Ectopic pregnand Other (specify)	су		-	23d. Date of delive Month	ery Day Year
ras, r	quires that en signed b	by P	Part II. Other significa	ant conditions o	ontributing to death	but not resulting	g in the un	derlying cause g	ven in Part I.			co use contribute to t	X.
i Records	The law re ate has be page 2 sho	Completed								24a. W	utopsy erformed	24b. Were autoprior to codeath?	opsy findings available impletion of cause of
Z Z	Physicien: Th this certificate ral director, paç	Be (25. Was case referred examiner?	d to medical	Magaitali		77	To.		Death Check or	100		
5	Phys r this ral dir	. To	1 Yes 2 No 27. Manner of Death	•	Hospital: 1 Inpa		Outpatient	3LI DUA		-		e 6 □Other (Special	(y)
0	Attending For death. ctor: After by the funer	ation	1 Natural 2 Accident	5 Pending investigation	(Month, E	ay Year)	Injury	28c. Inju Wo	ork?]Yes 2∐No		De HOW II	nquiy occurred	
DIVIS	al or Attendi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 4 Homicide	6 Could not be determined	286. Place of I	njury - At home, etc. (Specify)	, farm, stre	et, factory, office	1	28f. Locatio City or	n (Street Town, S	t and Number or Run tate)	al Route Number,
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	edicai	29a. Certifier 1 (Check only 2) one) 2	Certifying Ph Medical Exam	ysician: To the besing and manner:	of examination	dge, death and/or inv	occurred at the testigation, in my	ime, date and popinion, death	place, and due to occurred at the tin	the cause ne, date	e(s) and manner as s and place, and due to	stated. the cause(s)
	To the	ž	29b Signature and tit	le of certifier					se number	b /	29d.	Date signed (Month,	Day, Year)
			May .	2017		no Di			0047	8	M	us 17	2005
			30. Name and addres	s of person who	completed cause of	death (Item 23:	a) (Type, F	Print)	2101	snetic	al.	Noik 1	Dr
	Sta	te	31. Date filed (Month,			trar's Signature	- 1		7100	1 75	7 -	1 11)0	20708
	Registr		~ AL	IG 24 20	109 Denne	un B.	400	Mad					

			1 - State of Ma	ryland /	,	artmen <i>rtificat</i>			and M		giene Reg. No.	609	28938
	Physici	an	1. Decedent's Name (First, Middle, Last) Raymond Colie							2. Date of De Month	ath Day	Year	3. Time of Death
1	/Medic	al	4a. Facility Name (If not institution, give street and number)	<u>.</u>		4b. City,	Town, or	Location of	of Death	08	23 4c. C	2009 ounty of Deat	
			Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age	/In land h	inth do .)	Silv If Under	er Sp	oring If Under	24 Hrs	O Data of Div		gomery	(04-4
	Funeral Director		577-10-9501 1₺ M 2□ F	(In yrs. last b	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da May 5,	y Year) 1921	9. Bitt Co	nplace (State or Foreign untry) DC
	rland ow at		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Lo	cation							10d. Inside City Limits
	ne Man 8a-f sh otified	ector	MD Montgomery	Rock	ville								1 □Yes 2X No
	with the	al Dir	10e. Street and Number 4714 Topping Road			10f. Zip					10g. Citize	en of What Co	untry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a." dical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Never Married 12 Never Never or Dates: 14	0		Vas Deced fYes, spec I □Yes 2		spanic Ori n, Mexican Specify:		ecify Yes or No Rican, etc.)		Race - Ame Black, White pecify:	
21215-0036	vithin 72 hou ane. than "natur a	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+		(Give I	dent's Usua kind of wor DO NOT us perviso	rk done d se retired		t of worki	ng		of Business/	ndustry
Maryland 2	id be filed v fental Hygie ked other i	To Be Co	17. Father's Name (First, Middle, Last) Joseph Louis Colie			727			er's Name	(First, Middle,			
lary	2 shour and M	_	19a. Informant's Name/Relationship (Type. Print)			_				l Route Numb	-	Town, State, Z	ip Code)
	s 1 and if Health item 27 other t		Mary Lois Colie /Wife 20a. Method of Disposition				,			e, MD 208		ation - City or T	Town, State
altimore,	Pages tment of I tant: If its jury or o		1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place cemet Parklaw				i		İ		le, MD	
Baj	permit Depar Impor any in		21. Sign turn of Funeral Service Licensee	10081	50	00 Univ	ersit	y Blvd	a w, s	Silver Sp	ring,		Home Inc.
1	Physician /		23a. Part 1. Enter the disease, or dom lications that caused to shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a	te Ru	ral	fuilv		g, such as	cardiac d	or respiratory a	rrest,		Approximate Interval Between Onset and Death
1	Examiner	L	Seo	sis									
2	cuted d ansit	Examiner	Sequentially list conditions, if any learling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence									
,0928	ficate be executed physician and s the burial-transit	dical Exa	resulting in death) Last Due to (or as a	consequence	of):								
x 687	ertificat ling phy e as the	Medic	IF FEMALE:								05-0114		
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certifix within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown 23c. If yes, outcome of the past 12 months? 4 Pregnant at 9 Unknown U	Fetal deal		Ectopic p Other (sp					23	d. Date of deli Month	very Day Year
ords, F	w requires that s been signed I should be det	þ	Part II. Other significant conditions contributing to death but Congestive Heart			nderlying ca	ause give	n in Part I.			obacco use		the cause of death?
al Rec	n: The law ficate has b	Completed								1 □ Yes	rmed? 2 X No	prior to death?	topsy findings available ompletion of cause of
Ž	hyslcia his certi I directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatien	t 2 ☐ ER/C	utpatien	t 3 🗆 DO	Othe			re 5 ☐ Resid		☐Other (Spec	cify)
ouo	nding Pith.: After t	ation:	27. Manner of Death 1	Year) 28b.	Time of Injury	M 2	8c. Injury Work 1 🗆 Y	at ? /es 2 □!		28d. Describe l	now injury o	occurred	
Divis	To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injur building, etc.	ry - At home, f (Specify)	arm, stre	eet, factory,	, office			28f. Location (5 City or Tov		Number or Ru	ral Route Number,
	the Hospi in 24 hou the Funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of and manner state.	examination a	ge, death ind/or inv	occurred estigation	at the tim , in my op	ne, date an pinion, dea	nd place, th occurr	and due to the ed at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	10+1	2	29b. Signature and tiple of certifier	and the second second		290	D6	247	3			signed (Month	
	•		30. Name and address of person who completed cause of dease. SHAHRAM SANI			,	Glen	Road.	Silve	r Spring	, MD 2	0910	
į	Stat Registra		31. Date filed (Month, Day, Year) AUG 25 2009 Subsum	's Signature		N.J				F3	-		

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** (0:25.4M LILLIAN RUTH CROCKETT 21 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) County of Death **Examiner** PRINCESS AMPRILIPMENT 1 YEAR IT UNDER 1 YEAR IT UNDER 24 Hrs. iomerset. Manokin Manor Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min 1 □ M 2 😾 F 87 220-12-1065 Director Oct. 9, 1921 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Maryland Somerset Crisfield Funeral Director 1 ☐ Yes 2KINo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5160 S. Pomfrett Road 21817 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ∐Yes 2 🔀 No Black, White, etc. 1 ∐Yes 2 ∑x If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurses Aide Medical Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Augustus T. Forbush Lillian Guy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Crockett (Son) 26124 Cave Neck Road - Milton, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunnyridge Memorial Park 8/23/09 Crisfield, MD Robert H. Bradshaw, Jr. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 45CUD disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician a Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 1 ☐ Yes 2 ☑ No 2 No Be (25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural > 24 hours after death.
e Funeral Director: A letely filled in by the full 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 047074 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 54615BURY 1415 5. DIV1510 V N4/63 45 vel 31. Date filed (Month, Day, Year) State Registrar

Division of Vital Records, P.O. Box 68760,

6.25 Am

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Mary	•	artment of F rtificate of I		, ,	ene . No. 2 A A Q	28911
	Physici	an	1. Decedent's Name (First, Middle, Last)	CA DIED				2. Date of Death SEPT. 3		3. Time of Death
· Na	/Media	cal	LOIS VIRGINIA 4a. Facility Name (If not institution, give s			4h City Town o	r Lagation of Dageth	SEPT.3,		9:30P M
	Examir	ier	9999 FAULKNER				r Location of Death LKNER		4c. County of Death	1
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Pay, Y		nplace (State or Foreign intry)
	land ow		Usual Residence of Decedent 10a. State 10b. County	100	: City, Town or Lo	cation				10d. Inside City Limits
	a-f sh	ioi	MD. CHARLES	S		FAULKN	ER			1 □Yes 2X No
	or 28	Dire	10e. Street and Number			10f. Zip Code			. Citizen of What Cou	intry?
	eath with ins 23a or	Funeral Director	9999 FAULKNER	ROAD 2. Was Decedent Ever	in U.S. 13)		632		S.A.	ican Indian
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Actical Examination until by purified.	b	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces? 1 □Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 □ Yes 2 □ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	Black, White,	etc.
15-0	"natur	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occup	ation during most of work d)	ing 16	b. Kind of Business/Ir	ndustry
212	withir jiene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		OMEMAKE	•		WN HOME	
	e filed al Hyg d other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, Mai	iden Surname)	
Maryland	d Ment d Ment narked natic e	၉	THOMAS WEBESTI					RGINIA		
Ma	nd 2 sh ulth an 27 is r r traur		19a. Informant's Name/Relationship (Type VIRGINIA FARRE)	,		BOX 1	and Number or Run FAULKNE		City or Town, State, Zi	ip Code)
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition	20		sition (Name of natory or other place		- ,	c. Location - City or T	own, State
tim	Ly and Pe		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	MET	ROPOLIT	AN CREM	ATORY 9-	-12-09AL		
Ba	permit. Pa Departmer Important: any injury once.		21. Signature of Funeral Service License	R	11.	A PLATA	<u>, MARYLAN</u>	SERVICE DD 20646		
E		170	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	cations that caused the ce cause on each line.		and the same		or respiratory arrest		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a cor		Can	cen			
	Examiner		Sequentially list conditions b.							
Q .	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the cause of t	Due to (or as a cor	sequence of):					
) _{\$}	execuan and rial-tra	Exar	that initiated events cresulting in death) Last	Due to (or as a cor	sequence of):					
68760,	tificate be executed g physician and as the burial-transit	edical	d	-						
9 X	certific Iding p		IF FEMALE:	3c. If yes, outcome of pro	egnancy				2010	
P.O. Box	The law requires that the death cert ate has been signed by the attendin bage 2 should be detached for use a	Physician/W	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 21 No 9 □ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of deliver Month	Day Year
S, F	res that signed b	by P	Part II. Other significant conditions con	tributing to death but not	resulting in the ur	nderlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Records,	w requir been s should	eted						1 🗆 Yes	2 No 3 Pro	bably 4 Unknown
Rec	The law cate has l page 2 s	Completed						24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
		Be Co	25. Was case referred to medical				26. Place of Death		No 1 □Yes	2 □No
of V	ys is is	၉	1 les 5 2 100	ospital:	2 ☐ ER/Outpatien	t 3 DOA Othe			e 6 ☐Other (Spec	ify)
	ding F h. After funera	tion:	27. Manner of Death 17 Natural 5 Pending 2 Decident investigation	28a. Date of Injury (Month, Day, Yea	(r) 28b. Time of Injury	Work	yat ⟨? Yes 2 □ No	28d. Describe how	injury occurred	
\leq	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	2 □ Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homicide determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, streecify)			28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	e Hospital 124 hours a e Funeral etely filled	Medical C	29a. Certifier (Check only one)	ician: To the best of my er: On the basis of exar and manner stated.	knowledge, death mination and/or in	occurred at the tirvestigation, in my o	ne, date and place, pinion, death occur	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the vithing to the comp	Me	29b. Signature and title of certifier			29c. License	e number	29d.	. Date signed (Month	, Day, Year)
			KAROH			03	835	7	9-4-	09
_	3		30. Name and address of person who cor	mpleted cause of death	(Item 23a) (Type, I	Print) Lapla	eta	ms:	2-0640	
	Sta Registra		31. Date filed (Month, Day, Year) SEP 1 0 9009	32. Registrar's S	ignature	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year DAVIS NANCY AUGUST 7:00 P 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) Months Days Hours 1 □ M 2 🕁 F 577**-**58-8064 AUG. 5 1945 WASHINGTON, DC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location X☐Yes 2☐No MD PRINCE GEORGE'S MITCHELLVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20721 1401 KINGS VALLEY DRIVE 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married BLACK 1 ☐ Yes 2 TXNo Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ÝRS COMPUTER ANALYST FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NANCY C. MINOR UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 KINGS VALLEY DRIVE MITCHELLVILLE, MARYLAND APRIL BARNES/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/31/2009 LANDOVER, MARYLAND HARMONY CEMETERY 5 ☐ Other (Specify) 4 Donation J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) THMI FATAL Due to (or as a consequence of) ENCEPHALOPATHY ANOXIC Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cr as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2**/2** No 2 🛭 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA

Physician: The law requires that the death certificate be executed ing physician and s as the burial-trans P.O. Box 68760, for use ed by the detached Division of Vital Records, has page After this certification of funeral director, p

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Hospital or Attending

Physician

/Medical

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Certification: To

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29a. Certifier

Funeral

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other than "natural", or items 23a or 28a-f showert, the Modical Examiner must be notified at

event,

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event once.

Physician

/Medical

Examiner

filed within 72 hours after death with the Maryland I Hygiene.

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only and manner stated. 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Yea

and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name

Registrar's Signatu

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend I tem 21 per FH 6895 9/14/09 dk
Them 2 State of Maryland / Department of Health and Mental Hygiene Amend Item 2 For Amend Item 2 State of Maryla State Registrar WCHD/SH 9/2/09 per Dr. Certificate of Death Reg. No. 2. Date of Death 8/21/2009 Month August 8, 2009 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Gabriel Dean Dingle 1350 М /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 21 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Year) 2009 Months **X**2 M 2□ F Davs Hours N/A Aug. **Director** Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene.
marked other than "natural" or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at PA Franklin 1 ☐ Yes 2 No Waynesboro Director 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 4364 Buchanan Trail East 17268 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2**X** No Specify Specify: White ≥ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

N/A 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 Is marked othe any injury or other traumatic event, once. Be (17. Father's Name (First, Middle, Last) Kyle Benjamin Dingle Meghan Kelsey Hobby ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kyle B. Dingle/ Father 4364 Buchanan Trail East, Waynesboro, PA 17268 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Cemetery 8-27-2009 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 22. Name and Address of Facility Douglas a. Fiery Funeral Home 21. Signature of Funeral Service Licensee DVR Douglas H. Fiery per DVR 1331 Fastern Blvd. N. Hagerstown, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2hrs. **Physician** Renal Agenesis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 I Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ŽX No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed been (24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed?

1 □ Yes 2 □ XNo certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2XZXNo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 □Yes 2 □No death. 2 Accident 24 hours after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 D57882 August 21, 2009 30. Name and advess of person who completed cause of death (Item 23a) (Type, Print) Theresa Ngwana-Mondoa (Month, Day, Year) 32. Registrar 251 E. Antietam St. hagerstown, MD 21740 32. Registrar's Signature State AUG 3 1 2009 Registrar

			For	State of Ma	arylan						ental Hy	giene	Э	
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Division of Vital Records,	Attending Physician: The law requires that the death certire death. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	l by	Taren. Other significant conditions	ontributing to death bu	at not res	uning in the	andenying c	iuse give	miniran.	1.			1	Probably 4 Unknown
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	F		30. Name and address of person who	completed cause of de	eath (Iten	n 23a) (Type	, Print)	الالا	0	110			////)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Inko Ensura All Capies Are Legible. Amend Item I per phys. 690 Ensura All Capies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last)
Howertine L. Farrell 2. Date of Death Month **Physician** 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **E**xaminer Baltimore City The Johns Hopkins Hospital Baltimore City If Under 1 Year If Under Months Days Hours 8. Date of Birth 9. Birthplace (State or Foreign 5. Scial Security Number 6. Sex Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 ŬX Sept. 29, 1945 62 Nebraska 480-54-5471 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at 1 X Yes 2 □ No MD Gaithersburg Montgomery Director 28a-f 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ō r items 23a or ner must be n 4 Mineral Springs court 20877 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Examiner Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ▼No Specify Specify: Brack þ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Specify only highest grade completed) lth and Mental Hygiene. 27 Is marked other than " traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Educational Reference library supply 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard W. Farrell, Sr Ester Swille ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any injury or other trainonce, Malvin N. Duncan (Husband) 4 Mineral Springs Court, Gaithersburg, MD 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from Sta 8/25/09 Rockville, MD Parklawh Mem. Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, P.A. 21. Signatur Funeral Service Li ense 246 N. Washington St, Rockville, MD 20850 23a. Part 1, Enter the diseas that caused the death. not enter the mode of dying, such as cardiac or respiratory arrest, or compli shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Acute respiratory distress syndrome disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Preumonia Sequentially list conditions, if any, loguring to manadate Examiner Due to for as a consequence off cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed physician and is the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical ass IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) ed by the at detached f Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 Tyes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 No or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 Mo 2 ER/Outpatient 3 DOA ပ 28a. Date of Injury
(Month. Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the Director: 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide Cify or Town, State) within 24 hours and To the Funeral Completely filled Hospital 1 (Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only and manner stated. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 14945+ 17, 2009 RES-000 ιD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Rina Khatri 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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State

Registrar

AUG 25

2009

back

09-064	29
Tanya	Dooher

State	of Mary	yland / I	Department	of Health	and Mer	ıtal Hygien

iya Dooner		SIA 1- For State Registrar	te of Maryland / De	epartment of Ce <i>rtificate of</i>		i wentai r		eg. No. 2 1	00 2201
Physici dical Exam	an/	1. Decedent's Name (First, Middle, Tanya	Last) Dooher	-			2. Date of Deat Month August 16	h —	3. Time of Death 1634 hrs
		4a. Facility Name (if not institution,			4b. City, Town, or I	ocation of Deal		4c. County of Dea	th
Funeral		Suburban Hospital 5. Social Security Number 6	i. Sex 7. Age (in	yrs. last birthday)	Bethesda	If Under 24Hi	rs. 8. Date of Bir	Montgomery th(MM/DD/YYYY) 9. B	irthplace (State or
Director	1	080-28-2350	1_M 2XF	86 _{Yrs}	Months Days			1923 Fore	^{ig} Russia
any		Usual Residence of Decedent 10a. State 10b. County		City, Town or Locati	ion				10d. Inside City Limits
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vith the Maryland s 23a or 28a-f show a	Director	10e. Street and Number 3614 Taylor	Street		10f. Zip Code 2081	15	1	og. Citizen of What Co USA	untry?
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f she riraumatic event, the Monter Examiner must be notified at once	Fune	11. Marital Status 1 Never Married 2 Mari 3 Xwidowed 4 Divor	12. Was Decedent Ever Armed Forces? 1 Yes 2X	No If Y	is Decedent of Hisp es, specify Cuban,	Mexican, Puer		White, etc.	rican Indian, Black,
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Baltimore, I permit. Pages I and Department of Heal Important: If item injury or other tra		21. Signature of Funeral Service	alda '	92	241 Colu	ımbia :	Blvd.Si		ICE,P.A. ing,Md2091
Physician /Medical		23a. Part i. Enjer the disease, or confailure. List only one cause of	n each line.	death. Do not enter t	he mode of dying,	such as cardiad	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries Due to (or as a consequent	nce of):					
	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequent	nce of):					-
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f Vit Physici er this c ral dire	To B	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatient	· o_ box	Other Nurs	sing Home 5	Residence 6 Oth	ner:
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Division ospital or Attendin hours after death.	Certification:		not be 28e. Place of Injury			uilding, etc.	or Town,	State)	Rural Route Number, City Ramp 495, Bethesda, M
the hin	Medical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	/sician: To the best of my kno	owledge, death occu tion and/or investiga	rred at the time, dation, in my opinion	ate and place, a , death occurre	nd due to the cau d at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)
	Me	29b. Signature and title of certifier	and manner stated.		29 c. Licens			29d. Date signed (A	
15		highi,	W.S		O.C.I	M.E.		August 17, 200	9
		30. Name and address of person v Ling Li, MD Assistan	who completed cause of death it Medical Examiner		et, Baltimore,	MD 21201			
S	tate	31. Date filed (Month, Day Year)	32. Registrar's Si	In Sark	5				

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month **Physician** 14:45 August 21 Rov Allen DeLawder /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 3951 Route 94 Howard Lisbon 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Min 1 🕅 M 2□ F Months Days Hours 218-28-7664 Director 82 MD Apr 14, 1927 Usual Residence of Decedent 10a State 10c City Town or Location show 10d Inside City Limits Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Director MD 1 ☐ Yes 2 No Howard Lisbon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 3951 Route 94 21765 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: If Yes, Give Year or Dates: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DeLawder Silvas Harry Rertha ဨ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Paul R. Johnson (Executor) 1809 Wilkens Avenue Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State All County Cremation 8/24/2009 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens HAIGHT FUNERAL HOME & CHAPEL. P.A. 160764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARPIOTYOPA ~ 10 4 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner VULSONAY DISLAR CHRONIC USS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 certificate 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred 1X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation 1 □Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8343 CHERCY HAVE LANGE TO 20707 MARTIRE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

		,	1 - State Registrar		Ce	rtificate of l	Death	Re	g. No.	20140
		37	1. Decedent's Name (First, Midd	lle, Last)				2. Date of Death		3. Time of Death
	Physici		Frances Hobbs E	stes				August 21,	, 2009 Year	2:40 pM
9	/Medic Examin		4a. Facility Name (If not institution	on, give street and number	•)	4b. City, Town, or	Location of Death		4c. County of Deat	h
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7	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year	if Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birti	nplace (State or Foreign untry)
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	Ba-1 s	cto	1 Direct		araicismi,	J				1 Yes 2 140
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
	23a	al	8519 Calypso Lane	9		20879			USA	
	dea F	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, White	
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Baltimore,	of H		20a. Method of Disposition 1 🕇 Burial 2 ☐ Cremation	3 Removal from State	a !	matory or other plac	(8)	Date 2	0c. Location - City or	Town, State
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at	permit. Pages Department of important: if if any injury or o		21. Signature of Funeral Service	Libensee	2	2. Name and Addres	ss of Facility Fra	ncis J. Col	llins Funeral	. Home Inc.
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Bo	atte d for	Physician	in the past 12 months?	1 Live birth	2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)	<u>'</u>		Month	Day Year
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Division	or Al	Certification:	4 Homicide determined	mined 200. Flace of II	ijury - At home, farm, st atc. <i>(Specify)</i>	reet, factory, office		City or Town,	eet and Number or Ru State)	rai Houte Number,
	urs arail		200 0 W . ATO 41							
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifyi (Check only one) Medica	ng Physician: To the bes I Examiner: On the basis	of examination and/or in	in occurred at the time evestigation, in my of	ne, date and place, pinion, death occur	, and due to the cau rred at the time, dat	use(s) and manner as te and place, and due	stated. to the cause(s)
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			12 AME	NOHIKK	1/1/2	401 Keg	Karch	DLUI)	Cuto 33	MD 20350

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

AUG 25 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** MARY reev EL. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner NNA 100115 trundel Social Security Number Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 30, 7. Age (In yrs. last birt 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Hours Min 386-12-8167 May Michigan Director Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits show Michigan Alcona Barton City 7 is marked other than "natural", or items 23a or 28a-f si traumatic event, its. Its Jostica Ever, it se must be notified Director 1 ∐ Yes 2**X2N**o 10e. Street and Number 2060 W. Trask Lake Road 10f. Zip Code 10g. Citizen of What Country? 48705 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2xxXIo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1 ☐ Yes 2 XXNo Specify \$ Specify 3 Vidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene important; If item 27 Is marked other than any injury or other traumatic event, Inc. Inc. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Nagel Clara Bell Charter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar Sandra Weinstein/daughter 663 Mallard Court Arnold, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore Crematory 8/18/2009 Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, n each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician trterioscleroti disease or condition resulting in death) /Medical Dunto (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events be executed burial-transi Exami and resulting in death) Last Due to (or as a consequence of Box 68760. the attending physician hed for use as the buria Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.0. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate Division of Vital 1 ☐ Yes 2 🗆 No 1 ☐ Yes Hospital or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No 27. Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 NPR/Outpatient 3 ☐ DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural n 24 hours after death.

The Funeral Director; After the further t 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npletely (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 0605

State Registrar 31. Date filed (Month

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ed cause of death (Item 23a) (Type, Print

istrar's Signature

ONE

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2000

			1 - State Registrar	,	Ce	rtificate of L	Death	R	eg. No. 2009	28950
	Physic	ian	Decedent's Name (First, Middle, Last Richard Edwa	'	ouser			2. Date of Deat	20° 2009° 200	3. Time of Death 11:20 PM
1	/Medi Examii		4a. Facility Name (If not institution, give		Ouser	4b. City, Town, or	Location of Death	**agase	4c. County of Deat Anne Arun	h
	Funeral Director		5. Social Security Number 6. S 172–36–8093	ex 7. Age (In) M	vrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day Feb. 10	9. Birt	hplace (State or Foreign untry) nsylvania
	e Maryland sa-f show	Director	Usual Residence of Decedent 10a. State 10b. County MD Anne		City, Town or Lo	ocation				10d. Inside City Limits 1 □Yes 2 🎞 No
	th with th	al Dire	10e. Street and Number 1005 Shire Court			10f. Zip Code 21114		1	0g. Citizen of What Co USA	untry?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Modical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 19		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 ☑ No	spanic Origin? (Spe n, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Whi	, etc.
Maryland 21215-0036	ithin 72 ho ne. nan "natu i Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	ation luring most of workin)	ng	16b. Kind of Business/i Anne Arund	ndustry el County
d 21	filed w Hygier sther th	CO	17. Father's Name (First, Middle, Last)	<u>5+</u>	Teach	ner	18. Mother's Name		Roard of Ed	ucation
/lan	12 should be fi h and Mental H r is marked ot raumatic ever	To Be	Elmer H. Frankho	user			Margaret			
Mar	d 2 sho th and 7 is ma trauma		19a. Informant's Name/Relationship (Tarol Ann Frankho	,		ng Address <i>(Street a</i> Shire Ct.			; City or Town, State, 2	(ip Code)
re,	is 1 and 2 of Health item 27 i		20a. Method of Disposition	201		sition (Name of matory or other place		on, MD	21114 20c. Location - City or	Fown, State
Baftimore,	. Pages tment of I tant: If ite jury or o		1 ☐ Burial 2 🗷 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	nemoval nom State		Crematory	8/24/	2009	Baltimore,	MD
Bal	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licen	see		2. Name and Addres	. 10		neral Home e, MD 207	15
	Physician /Medical		23a. Part . Enter the disease, or come shock, or heart failure. List only disease or condition resulting in death)	a. Caeca	eath. Do not ent		g, such as cardiac o			Approximate Interval Between Onset and Death
	Examiner			Due to (or as a cons	sequence of):					
	cuteo nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	sequence of):					
68760,	ertificate be executer ling physician and e as the burial-transi	Medical Ex	resulting in death) Last	Due to (or as a cons	sequence of):					
Box 6	death certificate be execut e attending physician and d for use as the burial-tran		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of preduced in the control of	etal death 3 [Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
9. O	that the de ned by the detached	Physician/	9 🗆 Unknown	9 🗆 Unknown						
Hecords,	I he law requires that the death cate has been signed by the attendage 2 should be detached for us	þ	Part II. Other significant conditions of	Thrive		nderlying cause give	n in Part I.		acco use contribute to	the cause of death?
		Completed						24a. Was ar autopsy perform 1 □ Yes 2	y prior to d	topsy findings available ompletion of cause of
VITal	Pnysician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Death	(Check only one		
DIVISION OF	nding Physician: th. : After this certific e funeral director,	tion: To	27. Manne of Death 1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day, Year)	ER/Outpatier 28b. Time of Injury	28c. Injury Work	4 LI Nursing Hor		nce 6 ☐ Other (Spec w injury occurred	rify)
DIVIS	to the hospital of Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - Al building, etc. (Spe	t home, farm, streecify)	eet, factory, office	2	8f. Location (Sti City or Town	reet and Number or Ru , State)	ral Route Number,
	re Hospir 24 hour e Funera etely filk	Medical (29a. Certifier (Check only one) Medical Exam	/sician: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or in	n occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	and due to the ca ed at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
ŀ	vithir To th comp	Me	29b. Signature and the of certifier			29c. License			9d. Date signed (Month	
	. a.l.		30. Name and address of across with	ompleted source of death (III	tom 00s) /=	Drint)	1028		08-21-	
0	HUH		30. Name and address of person who c	m.D-600) RIdo	jely Ave	inve#z	31 Ann	apolis nu	021401
	Sta Registra		31. Date filed (Month, Day, Year) AUG 24 20	32. Pegistrar's Sig	1 1	a del				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Lester Joseph FINVER August 21 2009 5:05 P /Medical 4c. County of Death 4b. City, Town, or Location of Death Rockville 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Montgomery Hospice Casey House If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F Director New York May 28, 1921 131-07-3448 88 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland 1 and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a.f באישיי 10a. State 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f sho event, I'm Medical Examination to ust by northed at 1 ☐ Yes 2 🂢 No Director Montgomery Kensington Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20895 United States 3618 Littledale Drive #317 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WW II white ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Naval Systems Supply Analyst |Federal Government 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Seiden permit. Pages 1 and 2 should be Department of Heatth and Mental Important: If item 27 Is marked any lijury or other traumatte ev once. Max Finver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2 Clemson Court, Rockville, MD 20850 Paul Finver, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 08/23/09 Olney, MD ^{22. Name and Address of Facility} Torchinsky Hebrew Funeral Home 21. Signature of Fureral Stvice Lice see 401008 254 Carroll St., NW, Washington, DC eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, The disease, or complications that caus eart failure. List only one cause on each Approximate Interval Between Onset and Death 23a. Part 1. Immediate Cause (Final disease or condition resulting in death) **Physician** Septicemia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (produce or injury) Due to (or as a consequence of) Examine law requires that the death certificate be executed that initiated events resulting in death) Last and physician a s the burial-t Due to (or as a consequence of) Box 68760. Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 Yes 2 No 3 Probably 4 Unknown cate has been signal page 2 should b Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🚺 No 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospice Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 🔼 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) chou, August 22, 2009 D63748 Koud 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne Kouatchou, M.D., 6001 Muncaster Mill Road, Rockville, MD 20855 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 25 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MARGARET August 17, 2009 FENISON 1:35 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Aastoria House II Columbia HOWARD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Mar. 19,1929 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2**X** F Months Days Hours Min. Alabama 370-26-8629 80 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Item 27 Is marked other than "natural", or items 23a or 28a-f shot other traumatic event, Its Involcal Event recommended as Director 1 Yes 2 No MD Howard Columbia 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 6636 Cedar Lane 21044 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □Yes 2√ No If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 3 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) Home Health Care Provider Health Services 8th alth and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Bell Henrietta Stanton 19a. Informant's Name/Relationship (Type. Print) (Daugnter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If Item 27 Is
any Injury or other trau Ernestine Fenison-Peoples 9642 Lambeth Court, Columbia, MD 21046 Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Plac of Disposition (Name of erry, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donarion 5 ☐ Other (Specify) 3 🗆 Rer bouls Cemetery 8/20/09 Germantown, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. Anaral Service Lic 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only Approximate Interval Between Onset and Death rications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated expense. Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the aftending p for use as use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Ö the 1 ☐ Yes 2X No 9 Unknown 9 Unknown is been signed by the should be detached σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s performe certificate 2 XNo 2 No 1 □ Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 K Other (Specify) ASS't Living 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 24 To the I and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D30641 8/18/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year) AUG 25 2009

Ramesh Sabapathi, M.D. 32 Registrar's Signature

			For State	State of Ma	ryland / Depa	artment of H			200 200 20	0 00000
			Registrar 1. Decedent's Name (First, Middle, La.	at!	Ce.	Tillicate of L	Jeani	2. Date of Dea	Reg. No.	14 / 15 J O J
	Physicia	an	, , ,	,				Month	Day Y	'ear 3. Time of Death
	/Medic		Sarah Allman For			4. 60. 7	Lastin of Dark	Aug 25,	2009 4c. County of	7:25 P M
	Examin	ner	, , ,	e street and number)			Location of Death			_
en fin	F		5209 Palco Place 5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday)	Colleg	e Park If Under 24 Hrs.	8. Date of Birt	h 9	e George's B. Birthplace (State or Foreign
	Funeral Director			- 14-	5 Yrs.	Months Days	Hours Min.	(Month, Da Aug 23	y, Year)	Country) orth Carolina
7	-		Usual Residence of Decedent			l		Mug 25	1924 N	orth Carolina
	ylan how	,	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	s Mar	당	Maryland Prince	George's	Colleg	e Park				1X Yes 2 □ No
	th the	Director	10e. Street and Number		, ,	10f. Zip Code			10g. Citizen of Wh	at Country?
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Evertine must be notified at		5209 Palco Place			2	0740		USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	14. Race	- American Indian, White, etc.
S O	or it	by Fi	1 ☐ Never Married 2 ☐ Married	1 □Yes 2X No If Yes, Give)	1 □Yes 2X No	Specify:		1	White
212-003p	ural"		3 ☑ Widowed 4 ☐ Divorced	Year or Dates:						
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	2 should be fi h and Mental i ' is marked or raumatic eve	2	19a. Informant's Name/Relationship (19h Maili	ng Address (Street				tate Zin Code)
Mar	nd 2 sulth an and 2 sulth an and 27 is		Rosemary F. Rest							
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9	age ent o nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Gate of		8/3	1/09	Silver S	pring, MD
	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Lice	7		2. Name and Addres		1/09		
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			23a. Part 1. Enter the disease, or corn	plications that caused t						Approximate Interval Between
ı.			shock, or heart failure. List only Immediate Cause (Final	one ofause on each line			J ,		,	Interval Between Onset and Death
The State of the S	Physician /Medical		disease or condition resulting in death)	α	vascular	accident			_	
الجمعي	Examiner			,	consequence of): thrombos	ic				
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_	death e atten	icia	in the past 12 months? 1 □ Yes 2 ☑No	1 ☐ Live birth 2 4 ☐ Pregnant at		☐ Ectopic pregnanc ☐ Other <i>(sp</i> ec <i>ify)</i> _	У		Mont	h Day Year
5	t the by th ache	hys	9 ☐ Unknown	9 Unknown						
ຕົ້	w requires that the d been signed by the should be detached	by P	Part II. Other significant conditions	contributing to death but	not resulting in the u	inderlying cause give	en in Part I.	23e. Did t	obacco use contrib	oute to the cause of death?
ecords,	equire en siç ruld b							1 🗆 '	Yes 2 □ No 3	Probably 4X Unknown
	aw re as be	Completed						24a. Was	an 24b. W	ere autopsy findings available
r	: The law cate has b	mo							rmed? de	ior to completion of cause of eath? □Yes 2 □No
	ician: The certificate ector, pag	O	25. Was case referred to medical				26. Place of Dea			Tes ZUNO
	nding Physician: th. : After this certifics funeral director, p	0 B	examiner? 1 Yes 2	Hospital: 1 ☐ Inpatien	t 2 ☐ ER/Outpatie	nt 3 DOA Oth	er.		dence 6 ☐ Other	(Specify)
_	ng Ph ter th neral	Certification: To	27. Manner of Death	28a. Date of Injury (Month, Day,	Year) 28b. Time o	of 28c. Injur Worl			how injury occurred	. , ,,
<u>ō</u>	Attending or death. ector: Afte by the fune	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigatio		rear) injury		Yes 2 □ No			
<u> </u>	r Atte er de recto by th	tific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of Injur	y - At home, farm, st (Specify)	reet, factory, office		28f. Location (; City or To	Street and Number	r or Rural Route Number,
5	talo rsaft al Di led in	Ce						Only of 701	m, olaro)	
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun		29a. Certifier 1 XCertifying Pl	hysician: To the best of miner: On the basis of	f my knowledge, dea	th occurred at the time	me, date and place	e, and due to the	cause(s) and mar	nner as stated.
	the H nin 24 the F mplete	ledical	one)	and manner stat		1		artic time,	date and place, at	id due to the cadactay
	Voiri	Σ	29b. Signature and title of dertifler		1//	29c. Licens				(Month, Day, Year)
			1 four	MADO		D263	JOZ		Aug. 27,	2009
n	10		30. Name and address of person who			*	01 -			
16	/ -		Marc Shepard, Mi 31. Date filed (Month, Day, Year)		rwyn Hous	e Rd, S-l	U4, Colle	ege Park	t, MD 20	740
	Sta	ite	ALIG 2 P 2009	32. Registra	a digitaline	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September 2 **Physician** Baxter Franklin Fender, Jr. 2009 1810 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ceci1 Union Hospital E1kton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** 1XM 2□F Months Days Hours Min. 1919 Director 244-03-4722 90 March 3, North Carolina Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 📉 No Director Maryland Ceci1 Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 274 Molitor Road 21921 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? World 1 Mayes 2 □ No If Yes, Give War II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify. Specify: 3 Widowed 4 □ Divorced Yes, Give if. Pages 1 and 2 shours to manage attent of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural". White "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Manager <u>Automotive</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Baxter Franklin Fender Catheryn Taylor 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Webb Fender/Son 44 Stardust Drive, Newark, DE 19702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State Department o Important: If any injury or once. 4 Donation 5 Dother (Specify) R. A. Ferris & Co., Inc. 3, 2009 West Chester, PA 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signat e of Funeral Service Licensee 103 W. Stockton Street, Elkton, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence or cuseas /Medical Examiner congestive Sequentially list conditions, if any leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or an a consequence of): The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 **√**00 Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗷 No 1 🔲 Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attendential 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar LeFrak, M/D.,

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

21921

106 Bow Street, Elkton, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #15 Perater of Grand land I AD 00 arthment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Linda Μ. Farr /Medical 4a. Facility Name (If not institution, give street and number City, Town, or Location of Death 4c. County of Death Examiner AlleGAN umus - Braddoc 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year)
Dec 30, 1954 Birthplade (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 2□₹ Months Days Min Director 218-64-7642 54 MD Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Allegany Cumberland Director 1 □ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examinational December 2008. 416 1/2 Paca Street 21502 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 □ No Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) supervisor InfoSpherix 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Bowman, Sr. Dorothy (Grapes) Steinla မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Francis sister 715 McKinley Avenue Cumberland MD 21502 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 Burial 2 □ Crempation 3 □ Removal from State Sunset Memorial Park 9/3/2009 Cumberland MD 4 ☐ Donation /5 ☐ Other (Specify) 21. Signature Funeral Fervice 22. Name and Address of Facility Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part4. Enter the i ease, shock, or heart is lure. L r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only of cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Tred disease or condition resulting in death) **Physician** /Medical Examiner send serine + Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examine to (or as a consequence of): To the Hospital or Attending PhysIcian: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit physician and s the burial-trans resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier LEcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tiple 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

AVROMATIS
32. Registrate Signature

umberland MD 21503

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Elsie Yvonne Gibbons August 23, 2009 P^{M} 6:00 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Manor Care Nursing Home Montgomery Wheaton 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 578-36-3322 93 July 5, 1916 Aldie, VA Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9011 1st Street 20706 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 Never Married 2 Married □Yes 2 🔀 No 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 9 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Philip Sutphin Mary Agnes Langley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce L. Catalano / Daughter 9011 1st Street, Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 8/27/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 mon QUMD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final _{a.} Dementia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury Due to (or as a consequence of): Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Peripheral Vascular Disease 24a. Was an autopsy performed Depression 2 🖾 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🔀 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

r than "natural", or items 23a or 28a-f shor

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the Maonce.

with the Maryland show

death

filed within 72 hours after

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Records,

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Examine Physician/Medical \$

certificate be executed and burial-trar physician the burial attending ase for 1 the detached þ signed I been page 2 s certificate or Attending Physician: After death fter death

Completed Be Certification: To by the

Ω	To the Hospital of within 24 hours at To the Funeral D completely filled it	
	To the within To the comple	
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Medical

31. Date filed (Month, Day, State AUG 2 6 2009 Registrar

27. Manner of Death

5 Pending

1 X Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 □Yes 2 □No investigation 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

29c. License number D58962

8/24/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shashank Gnyanesh Patel, 18121 Georgia Avenue, Olney, MD 20832

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Year WILLIAM **DOUGLAS** GARRETT 2009 1045PM /Medical tagust 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGE If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 09-119-11 929 TEXXS 1-2 M 2 □ F 79 467-36-3642 **Director** Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Madical Experimentment be notified Director MD PRINCE GEORGE tyElYes 2 □ No BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 2004 CONNOR COURT UNIT#G 20721 items 23a U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1√2 Yes 2 □ No Black, White, etc 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married o, 1 □Yes 2 No BLACK Specify δ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) GOVERNMENT LETTER CARRIER Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, II once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be ပ WILLIAM HENRY GARRETT RUTH FULLER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRETA C. GARRETT/WIFE 2004 CONNOR COURT UNIT#G BOWIE, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ty Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY 8-29-2009 BRENTWOOD, MARYLAND Signature of Puneral Se 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician EDVA2 UTE disease or condition resulting in death) /Medical Due to (or as a consequence of): HOBET PAILURE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trar Due to (or as a consequence of): Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2 X No 1 □Yes director 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2. No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day, Year) . Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 5 Pending 2 Accident investigation 1 ☐Yes 2 ☐ No within 24 hours after deatl To the Funeral Director; filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and tith of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland

DASHOTTAK M.D. 31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7201 HANOVER PACKWAY 32. Registra s Signa

Registrar

SUITE A GREEN SELT NID DOTTO

		Please	Type or Prin					•		•	
		For State	State of Ma	aryland /				Mental Hy	/giene	2000	28958
		Registrar 1. Decedent's Name (First, Middle, L.	aetl		Cer	tificate of	Death	2. Date of De	Reg. No.	from the total	3. Time of Death
Physicia		- LIZABOT	151)	(-3/	e ASO	^/	Month	Day	Year	CIISA M
/Medic		4a. Facility Name (If not institution, ga	0 1				r Location of Death	4060	4c.	County of Dea	th 1
,		Some RFOR	20 P2	Ace	-	ANI	NAPULI	5		tone	4pumoll
Funeral			Sex 7. Age 1 ☐ M 2 ☑ F	e (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 2 / 1 / 1	rth av. Year)	9. Bii	thplace (State or Foreign ountry) MD
Director		Usual Residence of Decedent		77	1,0.			2/1/1	. 910		FID
iryland show	_	10a. State 10b. County		10c. City, Tov	vn or Loc	cation	-				10d. Inside City Limits
he Ma 18a-f s	Director	MD Anne Ar	undel	(Chur	chton					1 ☐ Yes 🔏 🖟 No
with t		10e. Street and Number 5568 Franklin Bly	7.d			10f. Zip Code 207	722		10g. Cit	izen of What C	ountry?
ms 23	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. V		lispanic Origin? (S _i an, Mexican, Puerto	pecify Yes or N	0-	14. Race - Am	erican Indian,
after or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	No		Yes, specify Cuba ☐Yes 2x1100	an, Mexican, Puerto Specify:	o Rican, etc.)		Black, Whit	e, etc. White
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n 72 h "nat	Completed	15. Decedent's E (Specify only highest g	rade completed)	T	a. Deced Give I life. D	lent's Usual Occup kind of work done (OO NOT use retired	ation during most of work d)	king	16b. Ki	ind of Business	/Industry
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ould b Meni arked	2	George Phillips					Maude Br				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, it is involved Evancing in items 12a or 28a-f show once.		19a. Informant's Name/Relationship Barbara Vandergra					and Number or Ru ill Rd.	ral Route Numl Oakton			Zip Code)
t Heal		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of	i	Date		ocation - City or	Town, State
Page: nent o int: If		txBurial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec		St. Jo	osep!	h's Cemet	ery 8/2	4/2009	Bel	tsville	, MD
permit. Departr Importa any in[t		21. Signature of Funeral Set in	nsee		22	. Name and Addre	ss of FacilityHar	desty F	uner	al Home	P.A.
		a. d. Au				2 Ridgely		nnapoli		D 21401	
		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final	nplications that caused one cause on each lin	the death. Do	not ente	21 122	D 20 50 5		arrest,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. AD	a consequence	Of the	DON	DONTH	-			Cyens
Examiner			b de to (or do t	a consequence	. 017.						,
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to or as	a conse µence	off:						
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icate be exphysician the buria	_		d								
that the death certificate ted by the attending physic detached for use as the b	Physician/Medica	IF FEMALE:									
attend for use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal deat		Ectopic pregnanc	у			23d. Date of de Month	elivery Day Year
the de	iysic	1 □Yes 2 ØNo 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 ∟	Other (specify) _					
s that med b	by Pr	Part II. Other significant conditions	contributing to death bu	ut not resulting	in the un	derlying cause giv	en in Part I.	23e. Did	tobacco u	use conflibute t	o the cause of death?
w requires that s been signed t s should be deta								1 🗆	Yes 2	∐ No 3 ☐ F	robably 4 🗌 Unknown
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sician: The law s certificate has t irector, page 2 si	Be c	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	A 🗆 ED/O		Oth	er:			/ / 4	SISTEDLIVING
g Phy ter this neral d	n: To	27. Manuer of Death	28a. Date of Injur (Month, Day	ry 28b.	Time of Injury	28c. Injur Worl	4 LI Nursing H	ome 5 ☐ Res 28d. Describe			ecity) FCI CCI
endin sath. or: Afr he fur	atio	1 Natural 5 Pending 2 Accident investigation	on	y, 16a1)	ii iju: y		Yes 2 □ No				
or Att	Certification: To	3 Suicide 6 Could not 4 Homicide determined		iry - At home, fa c. (Specify)	arm, stre	et, factory, office		28f. Location City or To	(Street an wn, State	nd Number or F	tural Route Number,
spital		29a. Certifier 1 Certifying P	Physician: To the best of	of my knowledg	ge, death	occurred at the ti	me, date and place	e, and due to the	e cause(s) and manner a	as stated.
To the Hospital or Attending Physician: The law requires that the death certificate to within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physis completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner sta	f examination a	ind/or inv	estigation, in my c	ppinion, death occu	rred at the time	, date and	d place, and du	e to the cause(s)
Veith Common Com	Σ	29b. Signature and title of certifier	11	21	7	29c. Licens	e number	5	29d. Da	te signed (Mon	th, Day, Year)
	-	20 Name and Address of save	completed assessed	noth (Itom 92-1	(Time)	2 sint)	1000		114	GUST/	8,201
45		30. Name and address of person who	NUKAN	Section (Item 23a)	ype.	teraws i	HIGHMAS	Mill	arx	wie N	1021108
Sta		31. Date filed (Month, Day, Year) AUG 21	2000 32. Registra	ar's Signature	6 .	6. 41		1			
Registra	ar	HUU & I	LUUJ DENS	un p	. 1	aver					

09-06226 Marc Grant Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

viai e orații	1- For State AMED #1 PEPT MER. Registrar 8/19/09 AACO HEALTH DEPT. CMH Certificate of Death	Reg. No.	10 2205
Physician	n/ 1. Decedent's Name (First, Middle,Last) 2. Da	ate of Death	3. Time of Death
Medical Examin	Marc Elliott Grant 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	onth Day Year igust 9, 2009 4c. County of De	1317 hrs
	Civista Medical Center La Plata	Charles	sau i
Funeral Director	250-27-1681 1XM 2 F 47 Yrs. Months Days Hours Min. C	Date of Birth (MM/DD/YYYY) 9. Fo Fo	Birthplace (State or reign Mary Land Country)
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	-	10d. Inside City Limits
<u> </u>	VA Fairfax Fort Belvoir		1 X Yes 2 No
Maryland 28a-f show d at once,	VA FAIRIAX FOR BEIVOIR 10e. Street and Number 10f. Zip Code 22060	10g. Citizen of What C	country?
th the Maryland 23a or 28a-f sho notified at once,	5997 Denty Place 22060	USA	
ath wi items ist be	11. Marital Status 1 Never Married 2 Married 12 Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 No		nerican Indian, Black,
after de	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 X Yes 2 No 1 Yes 2 X No specify:	Specify: Bl	ack
hours natur	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work during most of working life. DO NOT use retired)	one 16b. Kind of Busine	ss/Industry
136 hin 72 e. than "	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 16a. Decedent's Usual Occupation (Give kind of work of during most of working life. DO NOT use retired) Soldier 17. Father's Name (First, Middle, Last)	U.S	S. Army
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. T is marked other than "natural", or items 23a or 28a-f she are even; the Medical Examiner must be notified at once.		t, Middle, Maiden Surname)	
2121; uld be fill Mental I: marked	Joseph Grant Ruth H. G. 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural I		
imore, MD 2 Pages I and 2 shou ment of Health and n or other traumatic		Route Number, City or Town, Si Belvoir, VA	22060
re, N I and Thealth fitem er trau	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place)		or Town, State
Baltimore, permit Pages I ar Department of Hee Important: If ite njury or other tr	4 Donation 5 Other Specify: Beaufort Nat'l Cem. 8/17/	2009 Beaufort	, sc
Baltimore, MC permit Pages I and 2 st Department of Health an Important: If item 27 injury or other trauma	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall	Funeral Home	0745
Physician	6512 NW Crain Hwy. 23s. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resp	Bowie, MD 2 iratory arrest, shock, or heart	20 / 15 Approximate Interval
/Medical xaminer	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries		Between Onset and Death
X CANTILL OF	or condition resulting in death) Due to (or as a consequence of):		
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
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60, ate be ex obysician e burial -	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy		
876 rtificat ing phy as the		23d. Date of deli	very Day Year
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~ ± 50 0	5	23e. Did tobacco use contribute	to the cause of death?
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IVIS I or At after d Direct d in by	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f.	Location (Street and Number or or Town, State)	Rural Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	29a Certifier	py Oak Road and Gwynn R	
thin 24 mplete	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to come one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tand manner stated. 29b. Signature and title of certifier		
F S S S		29d. Date signed (Month, Day, Year)
	Theoder Mc King Jan on O.C.M.E. OGME	August 10, 20	09
0112	30. Name and address of person who complete bause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MI	D 21201	
State			
Registra			

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** <u>Louise V. Gilbert</u> 2009 August 12:38 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince Georges If Under 24 Hrs. 8. Date of Birth (Month, Day, April 23 If Under 1 Year 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) Year) 1 □ M 2 🕱 F Months Days 577-16-1611 89 1920 Washington, D.C Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 🎾 ☐ No Director Prince Georges Maryland Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6503 Horse Shoe Road Funeral 20735 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No If Yes, Give Year or Dates: Specify þ Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th. Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jacob R. Myers ဂ Daisy B. Strickler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edith Batton/ Sister 6503 Horse Shoe Rd. Clinton, Maryland, 20735 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery Aug. 24, 2009 Brentwood, MD. 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Poperal Service L 903035 Old Washington Rd. Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gauga ne disease or condition resulting in death) Due to (or as a consequence of): Sepsis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 □ Panding investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed attending physiclan and for use as the burial-trar P.O. Box 68760, been signed by the should be detached Division of Vital Records, cate has certificate ours after death.

eral Director: After this certific filled in by the funeral director, To the Hospital within 24 hours a To the Funeral C

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

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t of Health a

item 2

Department of Important: If it any Injury or o

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Certification: To Medical

29a. Certifier

State Registrar

and manner stated 29b. Signature and title of cert

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. mirin 31. Date filed (Month, Day, Year)

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			State	-	epartment of Health and N Certificate of Death		0.50	00001
			Registrar 1. Decedent's Name (First, Middle, Last)		- Detimodic of Bodin	2. Date of Deat		3. Time of Death
	Physicia /Medic		Gary Bruce Griggs			Aug 20,	, 2009 Year	9:15 A M
	Examin		4a. Facility Name (If not institution, give street and number		4b. City, Town, or Location of Death		4c. County of Deatl	
, τ			14303 Brandywine Heights 5. Social Security Number 6. Sex 7. A.	s Road ge (In yrs. last birtho	Brandywine Hav) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince Ge	eorge's
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7	D .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	ur Location	101		10d. Inside City Limits
o la company	f sho	or	Maryland Prince George's		andywine			1 Yes 2 No
4	r 28a	Director	10e. Street and Number	DI	10f. Zip Code	1	0g. Citizen of What Co	
4	23a o	ralD	14303 Brandywine Heigh	nts Road	20613		United	States
1	items	Funeral	11. Marital Status 12. Was Decedent Armed Forces'	Ever in U.S.	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
350	ll's all	by	1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	€ _{NO}	1 ☐Yes 2 ☐ NO Specify:		Specify:	White
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7 5	Hygie Hygie other t		12 17. Father's Name (First, Middle, Last)	ELe	ectrician 18. Mother's Nam	e (First, Middle, I		ic Schools
and	flo be flental rked c	To Be	Melvin John Griggs, Jr.		Lorraine R	ichardso	n	
ary	and N is ma		19a. Informant's Name/Relationship (Type. Print)		Mailing Address (Street and Number or Ru			
2, ≤	permit. Pages I and 2 should be med within 72 hours after death with the maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportant: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examin or must be notified at once.		Terry Griggs (brother)		100 Richmanor Terrac			
ם פר	rages nent of I int: If ite iry or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		crematory or other place) Aug 2	7, 2009	20c. Location - City or	e, Maryland
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Sion	ath. r: Afte e fune	atior	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of In (Month, D	ay, Year) Inju	me of 28c. Injury at Work? M 1 □ Yes 2 □ No	Edd. Boodings III	ow injury occurred	
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Š	withi Com	Me	29b. Signature and title of certifier	2 -	29c. License number	2	29d. Date signed (Mont	h, Day, Year)
			10 Nome and address of the state of the stat	double (the man and m	HO05597	-/	Huguet :	24,2009
P	Bla		30. Name and address of person who completed cause of Spluador Silvesty	304 H	ospital Drive	Chev.	erla M.	Angland
	Sta			trar's Signature	1.41	*	11	
	Registr	ar	AUG 2 5 2009 John	w B. x	parke			

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
	-	State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. No. 2 0 0 5 2
		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
Physicia /Medic		Lizzie E. Gross August 22 2009 5:45 p M
Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Funeral		Carroll Lutheran Village Health Care Westminster Carroll 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
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t ow		Usual Residence of Decedent 10a. State
a-f she	tor	MD Carroll Westminster
or 28a	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
s 23a		210 Luther Drive #110 21158 USA 11 Market Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Specify Yes or No-
item:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 □ Yes 2 □ N
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other vent, 1	BeC	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Menta arked	To E	Alonzo Leon Chaney Nettie Twigg
th and 7 is m		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
f Heal Item 2 other		William Gross/son 1745 Dennings Road New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
int: if		1 Specific 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadow Branch Cemetery Westminster, MD
Department of Health and Mental Hygiene. Important: If Item 273a or 28a-f show Important: If Item 271s marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Censee 2 Print Service Censee 2 Pri
0 9 2 0		412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
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nding p	Physician/Medical	IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery
e afte	sicial	200. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 1 1 1 1 1 1 1 1 1
d by the	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
signe d be o	d by	1 Yes 250 No 3 Probably 4 Unknown
sbeen	leted	24a. Was an 24b. Were autopsy findings available
ate has	Comp	autopsy prior to completion of cause of performed? death? 1 □ Yes 2 No 1 □ Yes 2 No
ertifica ector, I	Be C	25. Was case referred to medical examiner?
rthis o	. To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Lorunging Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
rth. r: Afte e fune	ation	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
ours an		29a. Certiffer Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
n 24 h he Fur pletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Withi To th	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
WJL		D 51705 8-24-09
2		30. Namo and address of person who completed cause of death (Item 23a) (Type, Print) N. PANSURIYA 349 Malwim DR, Westminstel, MD 21157
	ate	31. Date filed (Month, Day, Year) 32. Registrat's Signature

Registrar DHMH 17 Rev 1/2001

State

AUG 25 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b c. perFH, C897, 11/30/09 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 8/22/2009 **Physician** 3:00 p.M Robert L. Ham /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Manor Care Silver Spring Silver Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 243–24–4077 8. Date of Birth (Month, Day, Yea. 1/1/1926 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 83 1X M 2 ☐ F NC Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or items 23a or 28a-f show the M. dt al Examiner must be notified at Prince Georges Capitol HEights MD Y Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code USA 20743 905 Kayak Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2☐No If Yes, Give Year or Dates:1944-46 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2X No Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mail Clerk Government permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other trainmant. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William J. Garland Unknown 19a. Informant's Name/Relationship (Type. Print)
Delores J. Ham / wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 Kayak Ave Capitol Heights, MD 20743 20b. Place of Disposition (Name of Quanting of National Cem. Paryland Veterans Cem. 20c Location - City or Town, State Triangle, VA Cheltenham, MD 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 9/1/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen-22. Name and Address of Facility Bianchi 814 Upshur ST NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dementia /Medical Due to (or as a consequence of) Examiner Peripheral Vascular Disease Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Diabetes and burial-tra Due to (or as a consequence of) attending physician Hyperkalemia Physician/Medical as the asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ó in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9□Unknown 9 Unknown signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Seizure Disorder 1 Tes 2 No 3 Probably ₩XUnknown Completed Chronic Renal Disease 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ■ YENo 24a. Was an has autopsy perform rmeg: 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2000 No Other: 41 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of Injury 27. Manner of Death 1 Natural 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

hours after

within 72

the death certificate be executed

P.O. Box 68760.

Division or Vital Records.

Baltimore, Maryland 21215-0036

State Registrar

30. Name and address of person w 31. Date filed (Month, Day, Year)

29b. Signature and the of certifier

completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

53235 8/26/2009

Darryl Hill 13635 Baltimore, Avenue Laurel, MD 20707

32. Registrar's Signature AUG 2 6 2009

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2VSq Day Month 825 PM Physician James 3 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S 801 BUCKINGHAM DRIVE STEVENSVILLE 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) WEST VIRGINIA 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** Min. 1 X M 2 □ F Months Days Hours 69 Director 233-58-4418 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f show traumatic event, it. "Medical Extra from the motified at 1 □Yes 2 No Director MARYLAND QUEEN ANNE'S STEVENSVILLE 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 21666 UNITED STATES 801 BUCKINGHAM DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 □Yes 2 No Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify Specify: WHITE ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) AUTOMOTIVE MECHANIC 12 permit. Pages 1 and 2 should be flik Department of Health and Mental Hi Important: If item 27 is marked oth any Injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LUCILLE PITTON ARTHUR HURD 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 801 BUCKINGHAM DRIVE, STEVENSVILLE, MARYLAND 21666 JUDITH HURD/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition tery, crematory or other CHESAPEAKE 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State AUGUST 4 □ Donation 5 □ Other (Specify) STEVENSVILLE, MARYLAND 2009 CREMATION CENTER 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) 2 years anc /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): executed Exami and burial-tran Due to (or as a consequence of): Box 68760, iding physician certificate be Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atten law requires that the death 3 Ectopic pregnancy ō Year in the past 12 months? Month Day 5 Other (specify) □Yes 2□No signed by the a Ö 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>\$</u> 2 NO 1 🗌 Yes 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy certificate 2 200 1 ☐ Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home Hospital: 5 Residence 6 □ Other (Specify) 1 | Yes 2 | XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I or Attending Fafter death. After Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hydiana

		For State Registrar			artment of F rtificate of I			Reg. No.	2009	2898
ysicia Medic		1. Decedent's Name (First, Middle, Last) Hubert Hogan					2. Date of Dea Month August	Day	2009 Year	3. Time of Deat 3:20 P
amine		4a. Facility Name (If not institution, give : Larkin Chase	street and number)		4b. City, Town, or Bowie	Location of Death	n		ounty of Death	eorge's
neral ector		5/8-40-5142	7. Age (. M 2□ F	In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Biri (Month, Da Oct. 7,	v, Year)	Coul	place (State or For ntry) jinia
i-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Prince Ge		Oc. City, Town or Lo					1	10d. Inside City Lii 1 □Yes 2🏋
a or zoa	Direc	10e. Street and Number 6026 Westchester I	10f. Zip Code 20740			10g. Citize	en of What Coul	ntry?		
rinkrius	y Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Eve Armed Forces? 1 Tyes 2 XNo If Yes, Give	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.))- 14	4. Race - Americ Black, White,	etc.
Imporant: it tem 2/ is market other train natural, or items 23s or 26s-1 snow any Injury or other traumatic event, Immorian Evanting it us too incline at once.	Completed by	3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Edu (Specify only highest grade	Year or Dates:	16a Dece	dent's Usual Occup kind of work done o DO NOT use retired	pation during most of world)	king		d of Business/In	
nt, in	Com	Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last)		Sales	5	18. Mother's Nar	ne (First, Middle,		Supply Furname)	louse
atic eve	To Be						ice Broo			
traum	İ	19a. Informant's Name/Relationship (Ty Rebecca A. Hogan	·		ng Address (Street Gunwood		ural Route Numb rofton,		Town, State, Zij 21114	o Code)
or other		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F		20b. Place of Dispo		ce)	Date		ation - City or To	own, State
Injury o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service License		Bayview (Crematory 2. Name and Addre		/2009 - all Fun		more, M	1D
any lr		1/en/			5512 NW C	. 10		e, MI		5
s the burial-transit	edical Examiner	Sequentially list conditions, it amplications are cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Beguentially list conditions, it amplication is a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 if 4 Pregnant at til 9 Unknown	☐ Ectopic pregnand ☐ Other (specify) _	Эy		23	3d. Date of deliv	very Day Year	
uld be deta	þ	, and a significant of the signi						oid tobacco use contribute to the cause of dea ☐ Yes 2 ☐ No 3 ☐ Probably 4CCUni		
ector, page 2 sho	Completed						24a. Was auto perfo 1 □ Yes	psy ormed?		opsy findings ava ompletion of caus 2 No
irector	o Be	25. Was case referred to medical examiner? 1. Type 25. No. Hospital: 1. Type 25. No. Other							Other (Space	i6.)
mera	Certification: To	27. Manner of Death 1 X Natural 5 Pending (Month, Day, Year) 28a. Date of Injury (South Pending Injury) 28b. Time of Injury Work? 1 Yes 2 No					28d. Describe	lome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred		
completely filled in by the fu		4 ☐ Homicide determined	building, etc.	At home, farm, str (Specify) my knowledge, deaf		ime, date and plac	City or To	wn, State)		al Route Number,
letely	Medical	(Check only 2 Medical Exami	ner: On the basis of e and manner state	xamination and/or in	nvestigation, in my	opinion, death occ		, date and	place, and due	to the cause(s)
윤		29b. Signature and title of certifier			29c. Licens	se number		290. Date	signed (Month	, Day, rear)
dwoo		1 Core	13		D4F	5217			8/23/20	09

State of Maryland / Department of Health and Mental Hygiene State
Registrar WEND#17, 18, per INF, 8-28-09, EWW, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 17 **Physician** 2:00A M 08 2009 Sadie E. Harrison /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Fox Chase Rehab. & Nursing Center Silver Spring If Under 1 Year If Under 24 Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Days Months Hours 1 ☐ M 2 🖾 F North Carolina 10/31/1917 91 579-24-1527 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b, County 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No N/A Director Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number United States 20020 4261 Fort Dupont Terr., SE Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Black altimore, Maryland 21215-0036 Specify: 2 3₺Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7. th and Mental Hyglene. 77 is marked other than "n. Elementary/Secondary (0-12) 8 th College (1-4or 5+) Food Service Supervisor Federal Government 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Lenth Bowe Suda Bigelow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Pages 1 and 2 si partment of Health an **portant: If item 27 is r** / Injury or other trau 4261 Fort Dupont Terr., SE, Washington, DC 20020 Shirley Dunn/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Dat 2009 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □Removal from State Aug. 26, Department of Important: If any Injury or once. Washington National 4 □ Donation 5 □ Other (Specify) Suitland, MD 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licensee Tho 7400 Georgia Avenue, NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dementia-Advanced **Physician** /Medical Due to (or as a consequence of): Examiner Stroke Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) P.O. Box 68760, physician as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1☐ Yes 2X No 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an was autopsy performed? page certificate 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: Hospital: Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ZNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral Di hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and ti 0 D28656 Aug. 21, 2009 30. Name and address of person who completed cause of death (item 23a) (Type, Print)
Ravi Passi, M. D. 15225 Shady Grove Rd., Rockville, Maryland 20850 32. Registrar's Signatur 31. Date filed (Month, Day, Year) State AUG 24 2009 Registrar

09-06558 Lawrence S. Hale

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

vience 5. na		1- For State Criticate of Death Registrar		eg. No.	3. Time of Death
Physici dical Exam		1. Decedent's Name (First, Middle,Last)	Month August 21		2108 hrs
ulcai Exam	IIIGI	Lawrence Steven Hale 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location		4c. County of Death	
		788 East Kimberly Court Gaithersburg		Montgomery	
Funeral		J. Social Security Humber		rth(MM/DD/YYYY) 9. Birt Foreig	hplace (State or Nashington
Director		214-80-6107	Feb. 8	3, 1959 Co	untry) DC
21215-0036 Montal Hygiene. Mental Hygiene. revent, the Medical Examiner must be notified at once.		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 X Yes 2 No
yland -f sho once	호	Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code		10g. Citizen of What Cour	ntry?
Many r 28a	Director	Toe. Steet and Number		United State	9.5
ith the 23a c notif	밀	14 Marital Status 13 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic O	Origin? (Specify Yes or No	o- 14. Race - Ameri	can Indian, Black,
ath w items	Funeral	1 x Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexica	an, Puerto Rican, etc.)	White, etc.	
her de	匠	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specification of the specifi	ify:	Specify: Whi	te
urs af tural amin	ρ	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giver during most of working life. DO NO	ve kind of work done	16b. Kind of Business/	Industry
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otthin ene.	1 8	12 Assistant Manager	her's Name (First, Middle,	Driving R	ange
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	ြပ္မို	1 1 1	agdalena Flo		
127 Id be feet fental	o Be	Lawrence N. Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N			e, Zip Code)
MD 2 d 2 shou lth and N n 27 is n	٦	Anthony L. Hale (Brother) 4621 Aaron Court			
and 2 and 2 lealth item 2 traus		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,		20c. Location - City or	Town, State
OFF ges 1 it of F it. If i		1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Metropolitan Cremator	2/2//00	Alexandria	. Virginia
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		21 Signature of Funeral Segrice Licensee 22 Name and Address of Fact 10 East Deer 1	cility DeVol Fun	neral Home	, .==8
Baltimore, MD 212 permit. Pages I and 2 should be Department of Health and Ment Important: If item 27 is markinjury or other tranmatic ever injury or other tranmatic ever	1	I W Va TA AA K X X IV MIDUI A I GAI EDET SDILLY.	MD ZUOII		
Physician	_	23a. Part i. Inter the disease, of complications that caused the death. Do not enter the mode of dying, such a	as cardiac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and
/Medica		failure List only one cause on each line. Immediate Cause (Final disease a. Han ing			Death
(amine	1	or condition resulting in death) Due to (or as a consequence of):			
	l.	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			
	غ ا	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
2	Examiner	events resulting in death) Last Due to (or as a consequence of):			
the Hospital or Affending Physician: The law requires that the death certificate be executed him 24 hours after ceath. The Funeral Director: After this certificate has been signed by the attending physician and maked fill in his formeral director nace 2 should be detached for use as the burial - transit	<u> 4</u>	d			
60, ate be ex hysician e burial	Medical	UNPENDED AMENDED		23d. Date of delive	n/
760, ficate b	Ž	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ect	topic pregnancy	Month	Day Year
ox 6876 eath certifica the attending pherion of the control of the	.5	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		1	
Box 687 ne death certific the attending p	1 6	1 Yes 2 No 9 Unknown g Unknown	lag Di	tobacco use contribute t	a the sauce of death?
ires that the signed by t	7		THE CALL OF	Yes 2 ✓ No 3 Pr	
ires the	7		[24a, Wa		autopsy findings available
ords aw requi	1		au		completion of cause of
Cecor The law					Yes 2 No
tal Rection: The certificate	9	. I 25. Was case referred to medical	eath (Check only one)		
Tivision of Vital Records, at or Alending Physician: The law requires after ceath. Director: After this certificate has been is in the finered director nace 5 should in the finered director nace 5 should.		Yes 2 No 1 Impatient 2 EN Outpatient 3 BOA		Residence 6 Oth	er: Scene
of ing Pl	-		 Subject h 	be how injury occurred anged self	
tend tend eath.		1 Natural 5 Pending Pending Investigation Aug 21, 2009 2101 hrs		n (Street and Number or I	Rural Route Number City
Divis pital or Ar ours after of ters! Direct	ortification.	3 Suicide 6 Could not be determined (Specify) Single Family	or Town	n, State) Limberly Court, Gaither	
Spits hours ner l	- 1 (
To the Hospital or Attend within 24 hours after ceath. To the Funear! Director:	in in	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death	th occurred at the time, da	ate and place, and due to	the cause(s)
To the To the To the	Modiool	and manner stated. 29b. Signature and title of certifier 29c. License num		29d. Date signed (A	
61	•	O.C.M.E.	•	August 22, 200	9
		30. Name and address of person who completed cause of death (Item 23a)			
		Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimor	re, MD 21201		
	Star				
Reg		e 31. Date filed (Month, Day Year) AUG 24 2009 37. Registrar's Signatire			

DHMH 17 Rev 1/2001 OCME 2006

П	Physici	an	1. Decedent's Name <i>(First, Middle, Las</i> Peggy Louise Hi	aller					2. Date of Dea Month August		, 2009	3. Time of Death 7:59А. м		
mility.	/Medic	al	4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death				4c. County of Dea					
	Examir	er	Laurel Regional H				Laure	_		Prince George's				
	Funeral Director		5. Social Security Number 6. S 217-42-5435 1	ex □ M 2X F 7. Age	(In yrs. last birtl		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Jan 20,	1942	9. Birthp	lace (State or Foreign Tand		
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	tion				1	0d. Inside City Limits		
	Maryli fied of	tor	Maryland Montgome	ry	Silver							1 □ Yes 2 XNo		
	with the 3a or 28a	Funeral Director	10e. Street and Number 2900 Craiglawn Ro	ad			10f. Zip Code 2090	4		-	en of What Cour	•		
36	d 2 should be filed within 72 hours after death with the Maryland it and Mental Hyglene. It am arked other than "natural", or items 23a or 28a-f show traumatic event, it we first Evrorient or ust be notified at		11. Marital Status 1 □ Never Married 2 🔀 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 □ N If Yes, Give Ye ar or Dates:	ver in U.S.		as Decedent of H /es, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		A. Race - Americ Black, White, of Specify: Whi	etc.		
5-00	2 hour	ted	15, Decedent's Ed	ucation	16a.	Decede	nt's Usual Occup	ation	ing [16b. Kind	d of Business/Inc	dustry		
2121	d within 7 giene. ir than "r	Completed by	(Specify only highest gra	College (1-4or 5+	⊦)	life. DO		during most of work d)	arig	70	vn home			
р	e filed al Hygi I other went, t	Be C	17. Father's Name (First, Middle, Last)	• • •				18. Mother's Nam			urname)			
yla	2 should be fi h and Mental I is marked of raumatic eve	입	Henry Fillmore Me					Hilda Lo						
, Mar	s 1 and 2 sho f Health and I item 27 is ma other traums		19a. Informant's Name/Relationship (Howard Lee Hiller		290	0 Ci	caiglawn	Road Sil	ver Spr	ing,	Marylar	nd 20904		
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ∑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of cemetery	Disposit , crema Hil	tion (Name of Itory or other place L Cemete	ry 8/24/	²⁰⁰⁹		imore, N	wn, State Maryland		
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licent	sae a pera-	nt d	Dőr 44(Name and Addre DO Powde	Borgwardt r Mill Ro	: Funera bad Belt	l Horsvil	ne, PA Le, Mary	land 20705		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	olic of his that caused one cause on each line	the death. Do n							Approximate Interval Between Onset and Death		
d	Physician		Immediate Cause (Final disease or condition resulting in death)	Septic										
7	/Medical Examiner		rocarding in accumy		consequence o		Distres	s Syndron	20					
		Je.	Sequentially list conditions,	Due to (or as a	consequence o	f):		3 Dyridron	ie					
	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	ion Pne		nia ————							
60,	be exectan a		resulting in death) Last	•	consequence o	•	structio	n						
387	ficate physi s the t	dica		,d. Oas clic	Outlet	ODE	Structio	LI						
O. Box 68760,	at the death certificate be executed by the attending physician and tached for use as the burial-transit	ysician/Me	Physician/Me	ysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 gooths? 1 □ Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 Pregnant at 9 Unknown	2 🗌 Fetal death		Ectopic pregnand Other <i>(specify)</i> _	y		23	3d. Date of delive Month	ery Day Year
ds, P.	es this	þ	Part II. Other significant conditions of	ontributing to death bu	t not resulting in	the und	lerlying cause giv	en in Part I.			e contribute to to	ne cause of death?		
of Vital Records	w requir s been s should I	Completed							24a. Was	Ī	24b. Were auto	psv findings available		
- Be	The lay	dwo			· · · · · · · · · · · · · · · · · · ·				autor perfo 1 □ Yes	psy ormed? 2 X No	prior to co death? 1 □Yes	mpletion of cause of		
/ita	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of Dea						
of \	Phys this al dir	ဍ	1 ☐ Yes 2 🔯 No 27. Mapner of Death	Hospital: 1 Inpatie	nt 2 ER/Out			4 LJ Nursing H			Other (Specia	5/)		
	ding h. After fune	tion	1 △Natural 5 Pending 2 △ Accident investigation	(Month, Day	(Year)	jury	28c. Injur Worl M 1 □	yai k? Yes 2 □ No	28d. Describe I	now injury	occurred			
Division	I or Atten after deat Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, far . (Specify)	m, stree	et, factory, office		28f. Location (S City or Tox	Street and wn, State)	Number or Rura	al Route Number,		
_	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical C		vsician: To the best on the basis of and manner sta	examination and									
	To the within 2 To the comple	Me	29b. Signature and title of certifier	10,	1		29c, Licens			29d. Date	signed (Month,	Day, Year)		
	10			200	un		D	55703		AL	igust	21,2009		
			30. Name and address of person who	completed cause of de	eath (Item 23a) (Type, Pi	rint)	14.1	300 V	an D	usen F	Road		

DHMH 17 Rev 1/2001

State

Registrar

1 - For State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tsion Berhane MD Laurel Regional Hospital

31. Date filed (Month, Day, Year)

32 Registrar's Signature

AUG 25 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2009 5:00 AM William Odell Hack 28 august /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown Washington County Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X**) M 2□ F 81 1928 Maryland April Director 217-16-2188 Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Expression in the notified at 1 XYes 2 No Director Williamsport Maryland Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21795 USA 127 South Vermont Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1946-If Yes, Give Year or Dates: 1947 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1∐Yes 2⊠No Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) s 1 and 2 should be filed within thealth and Mental Hygiene. Item 27 is marked other than Truck Driver Auto Transport 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Helen Cromer Austin Beard Hoch, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Williamsport, Maryland 21795 Sarah E. Hoch - Wife 127 S. Vermont St. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial ≥ ☐ Cremation 3 ☐ Removal from State 4 Dogation 5 Mother & Pecify Entombrent Greenlawn Mem. Park 109-01-2009 Williamsport, Maryland 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signeture of Funeral S 425 S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Concer 16 months **Physician** ulon metastabe resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the Ses IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for 1 Month Day Year 5 Other (specify) ☐Yes 2☐No P.0. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ğ 1 Tes ဂ္ 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Attending Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. Hospital or Attendi 24 hours after death. Funeral Director: A etely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated

WH 4+1 State

To the I within 2

31. Date filed (Month, Day, Registrar

1138

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Tu Bui MD

pai Ct. Hagerstown 32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

058/95

29d. Date signed (Month, Day, Year)

9/2009

		1 - State of Maryland /	•	tificate of Death	ario ivie		eg. No.	nae	29970			
Physic /Med		1. Decedent's Name <i>(First, Middle, Last)</i> Erika Katharina Hillegas				2. Date of Deal Month USUS t		009 ^{ear}	3. Time of Death			
Exam		4a. Facility Name (If not institution, give street and number) 20863 Emerald Drive		4b. City, Town, or Location of Hagerstown	of Death			inty of Death	n County			
Funera Directo		5. Social Security Number 029-46-1729 6. Sex 1 M 2 F 66	oirthday) Yrs.	If Under 1 Year If Under 2 Months Days Hours	Hours Min. 8. Date of the (Month), Sept.		Year)		place (State or Foreign			
ryland		1	0d. Inside City Limits									
the Ma 28a-f s	Funeral Director	Maryland Washington County Hager	SLOW	10f. Zip Code		1	0g. Citizen	of What Cour	1 ☐ Yes 2X No			
ath with 23a or	ral Di	20863 Emerald Drive		21742			U.S.A.		,			
"72 hours after death with the Marylan "natural", or items 23a or 28a-f show	by Fune	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ※□ No If Yes, Give Year or Dates:		Vas Decedent of Hispanic Orig Yes, specify Cuban, Mexican, □Yes 2 No Specify:	gin? (Spec , Puerto Ri	ify Yes or No- ican, etc.)		Race - Americ Black, White, ^{ecify:} Whit	etc.			
	Completed	15. Decedent's Education (Specify only highest grade completed)	a. Deced (Give I life. D	ent's Usual Occupation aind of work done during most 10 NOT use retired) der Associate	of working	,	16b. Kind o	. Kind of Business/Industry S. Government				
filed within Hygiene.	Be Cor	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)										
12 should be f h and Mental I r is marked of traumatic eve	To B	Anton Marzoner			eth Huber							
				g Address <i>(Street and Numbe</i> 3 Emerald Driv								
permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other page.		20a. Method of Disposition ¹XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place cemet Walke.	on - City or To	own, State								
Definit. Departr Imports any Inje	20a. Method of Disposition **NXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Figure 1331 Eastern Blvd. N. Hagerstown, N.											
Physician /Medical		23a. Part 1. Enter the disease or complications that caded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
ath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Yea							
quires that an signed b	þ	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause given in Part I.			bacco use o	-	he cause of death?			
ician: The law requires the certificate has been signerector, page 2 should be controlled.	Completed						med? 2 Alo	4b. Were auto prior to co death? 1 □Yes	opsy findings available impletion of cause of 2 □ No			
Physicia r this certi	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient	Other		Check onl or		Other (Special	fy)			
Yo the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the sompletely filled in by the funeral director, page 2 should be detached	Certification:	27. Mann of Death 1	Time of Injury farm, stre	28c. Injury at Work? M 1 □ Yes 2 □ N et, factory, office	No	d. Describe he St. Location (S. City or Town	treet and N		al Route Number,			
e Hospita 24 hours e Funeral	edical Co	29a. Certifier (Check only one) 1	ge, death and/or inv	occurred at the time, date and restigation, in my opinion, deat	d place, ar	nd due to the o	cause(s) and late and pla	d manner as s ce, and due to	stated. o the cause(s)			
To the Comp	Me	29b. Signature and title of certifier	4	29c. License number		2		gned (Month,	-			
8		30. Name and address of person who completed cause of death (Item 23a)		7 0 9160 Print)			E E	. 21.0	m mp.			
St	ate	Michael Manth, Day, Year) 32. Tegistrar's Signature	A	Medical	(in	100	Was	ersh	un MD.			

			For State State Registrar	of Maryland		artment of He <i>rtificate of D</i>			iene eg. No. 2 A A	0 20071			
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat		3. Time of Death			
	Physicia /Medic			sier				Aug 23		2:00 PM			
	Examin	er	4a. Facility Name (If not institution, give street and 7209 Lansdale Str			4b. City, Town, or l	ocation of Death Heights		4c. County of Death Prince George's				
de "	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Fore				
ı	Director		579 48 0971 1□M 🔭	79	Yrs.	Months Days	Hours Min.	(Month, Day, May 3,	1930 Wa	ishington DC			
	pur *		Usual Residence of Decedent 10a, State 10b, County	10c. City, T	own or Lo	cation				10d. Inside City Limits			
	Maryla f sho	for	MD P.G.	,,		strict Hei	ghts			1 □Yes 2 □Xio			
	r 28a	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What	Country?			
	th with	al D	7209 Lansdale Stree	5		20747			United St	ates			
	tems	Funeral	Armed	ecedent Ever in U.S. Forces?	13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.			
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes, 3 ☐ Widowed 4 ☐ Divorced Year o	s 2 TANO Give XX r Dates:		1⊡Yes 2⊒No	Specify:		Specify:	White			
21215-0036	2 hou latura	ted	15. Decedent's Education (Specify only highest grade complete	11	16a. Deced	dent's Usual Occupa kind of work done do	tion	ing I	16b. Kind of Busine	ss/Industry			
21	ithin 7 ne. nan "n	Completed	Elementary/Secondary (0-12) College	e (1-4or 5+)	life. L	DO NOT use retired)	anig most or work	ng	Board of	f Education			
2	iled w Hygier ther th	S	12 4 17. Father's Name (First, Middle, Last)		Lit	orarian	18. Mother's Name	(First, Middle, I	Board of Education				
Maryland	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. In marked other than "ratural", or items 23a or 28a-f show immatic event, it is redieved.	To Be	Ward Henry			iel							
ary	shoul and M s marl umati	ř	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street a	nd Number or Run	e, Zip Code)					
Σ,	and 2 ealth a n 27 is		Andy Hosier (Son)			511 Norwood Court, Waldorf, MD 20602							
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Pacified Evan, I'm in 11 be rollflind an once.		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from the second sec		vland Veterans Cemetery 20c. Location - City or Town, State Cheltenham, Maryland								
ij	it. Parintmen rtant: njury		4 □ Donation 5 □ Other (Specify)	Mary						n, Maryland nc 6633 Old			
Ba	Depa Impo any i		21. Signature of Funeral Service License	linton, M									
			23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death.	Do not ent					Approximate Interval Between			
lia,	Physician	8 0	Immediate Cause (Final disease or condition	eccle	Me	to Cen	eli 4	inf	mai	Onset and Death			
	/Medical Examiner		resulting in death)	to (or as a consequer	nce of):	AA	JU 7	2,50	C1 - 1				
		ē	Sequentially list conditions, if any, leading to immediate b.	to (or at a consequer	nce of):	7 (01		0176	110	_			
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Cins	opsequence of):								
, 00	icate be executed physician and the burial-transit	EX.	resulting in death) Last Due	to (or as a consequer	ice of):	s the	ca.						
68760,	icate l physic the b	dical	d	101									
Box (w requires that the death certifices been signed by the attending should be detached for use as			outcome of pregnanc		75			23d. Date of delivery				
œ.	death	Physician/M	in the past 12 months?	ve birth 2□ Fetal de regnant at time of dea nknown		☐ Ectopic pregnancy ☐ Other <i>(specify)</i>			Month	Day Year			
P.0.	at the d by th etache	Phys	9 ☐ Unknown Part II. Other significant conditions contributing to		ng in the u	nderlying cause give	n in Part I	23e Did to	hacco use contribut	e to the cause of death?			
ds,	signe d be d	by	Part II. Other significant conditions contributing to	5 Eng	He	er-54c	28VS	1 □ Y		Probably 4 Unknown			
cor	w requ	Completed	Serve	(0)	² >	PI	7	24a. Was a	an 24b. Were	autopsy findings available			
Re	The lay te has age 2	ошр	GI	(31 p)		in		autops perfor					
ital	ician: The lav certificate has ector, page 2:	Be C	25. Was case referred to medical examiner?		•••	(26. Place of Deat						
≥	Physic this co		1 Yes 2 No Hospital: 1	☐ Inpatient 2 ☐ EF	R/Outpatier		4 Li Nursing Ho		ence 6 Other (5	Specify)			
ono	ding Ph h. After thi funeral	tion	27. Manner of Death 1 ★ Autural 5 Pending 2 Accident investigation	ate of Injury fonth, Day, Year)	Injury	Work	rai ? ′es 2□No	280. Describe n	ow injury occurred				
Division of Vital Records,	I or Attendi after death. Director: A I in by the fu	Certification: To	Z	I ace of Injury - At home ilding, etc. <i>(Specify)</i>	e, farm, str	reet, factory, office		28f. Location (S City or Tow	treet and Number of	r Rural Route Number,			
Ö	ital or rs afte ral Dir led in	Cert	4 El Tormoldo	namy, etc. (aposity)				City of You	n, State)				
	To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours affer death. To the Funeral Director. After this certificate has been signed by the attending for the Funeral Director. After this completely filled in by the funeral director, page 2 should be detached for use at	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On the and n										
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Attec	Och	29c. License	number	2	29d. Date signed (M	onth, Day, Year)			
) Hardy	7,0	mi) Doo	2474	76	08-20	42507			
	RRIA		30. Name and address of person who completed of	ause of death (Item)	3a) (Type,	Print) 913	Sites	cate	1000	132 H 100			
	UO 10 Sta	te.	31. Date filed (Month, Day, Year) 33	2. Registrar's Signatur	е	<u>ر ر</u>	1014	vvi ju	in a	105			
	Registr		AUG 25 2009	chown A.	pa	Ked							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 7:58 AM 31,2009 August Sally Ann Hoover /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick 305 Spring Gate Court Mount Airy 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours 163-36-9307 68 Director Oct.3,1940 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I'm Moden Examine must be notified at 1 XYes 2 □ No Director Frederick Mount Airy Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21771 305 Spring Gate Court Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 2 If Yes, Give Year or Dates: Specify: White 3 ☐ Widowed ★☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) GroceryStore Florist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Lucille Smith ဂ James H. Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20837 19a. Informant's Name/Relationship (Type. Print) 17101 Spates Hill Road, Poolesville, Maryland Jeffrey A. Hoover Baltimore, : If item 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 ō 1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) permit. Pages Department o Important: If i any injury or 3 ☐ Removal from State 9-4-09 Martinsburg, PA. Fairview Cemetery 21. Signature of Funeral Service 22. Name and Address of Facility Marzullo Funeral Chapel, P. A muchael 6009 Harford Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final IPLE **Physician** mos 1041 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of The law requires that the death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the s 1 ☐ Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has page 2 perform 1 □ Yes 2 100 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After thi funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending investigation nours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 0 within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number D31362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Frederick Ave, Gaithersburg Md. 20877 MARLENE T. HA 501 MAN 31. Date filed (Month, Day, Year) 2. Registrar's Signature State **SEP 1 0 2009** Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 Yeer Month Day **Physician** Lester Wordell Hess, Sr. 3, 5:30 AM Sept. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Parkton 18519 York Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 27, 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days Min. Months 87 Yrs. 165-16-1264 1921 PA Director Usual Residence of Decedent the Marylend 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ₩ode r then "neture!, or items 23a or 28a-f ehov the Mudical Exerciner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Parkton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number W IS 18519 York Road 21120 U.S.A. deeth Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [∆Ves 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Iron Worker Construction 8 permit. Peges 1 and 2 should be flie Department of Health and Maniel Hy Important: If Item 27 is marked othn any lighty or other treumatic event, 9088. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Erma K. LeBard Maurice Hess, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18519 York Rd., Parkton, MD 21120 P. June Hess, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Sept. 6 20c. Location - City or Town, State 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State White Hall, MD Wiseburg Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Signature of Funeral Service Licenses 24 Second Street, New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metasta ≗nysician 2 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Fine Indenting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burlei-trensit certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐ Pregnant at time of death ned by the e 9 Unknown 9 Unknown ate hes been signed pege 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacço use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an certificate hes autopsy perform? 1 ☐ Yes 2/2 No the Hospital or Attending Physicien: hin 24 hours after death. the Funeral Director: After this certifica 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No. ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. escribe how injury occurred Certification; 5 Pending investigation 1 Natural 1 Tyes 2 🗌 No 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Centrying Physician: To the best of my knowledge, death occurred at the fine, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Cal (Check only one) within 2 License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 9 10009 03 09 nee ۵(34 and address of person mpleted cause of death (Item 23a) (Type, Print) 30. Name Leg IT 10 31. Date filed (Month, Day, Year) 32. Re gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year DOUGLAS ASA HARSHMAN 03 AM ptember 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10851 Shanktown Road Big Pool Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min. 1 X M 2 □ F 217-56-1237 Yrs 58 April 9, 1951 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16812 Shinham Road 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 🂢 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Truck Driver Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Asa Danie1 Harshman Evelyn Elizabeth Stottlemyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucinda Ramacciotti, daughter 10851 Shanktown Road, Big Pool, Maryland 21711 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Zion U. Methodist Sept. 4,2009 Myersville, Maryland 4 Donation 5 Other (Specify) Signature of Fune II Service Licensee 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) + moon Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 26. Place of Death (Check only one) Sother (Specify) Dayghten Other: 4 Nursing Home 5 Residence

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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27 is marked other than 'r traumatic event, Ither

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Department of Important: If any Injury or once.

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Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine Be

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit Physician/Medical ≥ Completed Certification: To

Division of Vital Records, P.O. Box 68760, 🖔

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Yo 27. Manner of Death Natural

2 ☐ Accident

3 Suicide

29a. Certifier (Check only

4 Homicide

5 Pending investigation 6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Name, and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

State of Maryland / Department of Health and Mental Hygiene $\stackrel{<}{\sim} \mathbb{U}$ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death SEPTEMBER 2, **Physician** 2009 19:18 M **Imes** Benjamin /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** ALLEGANY WMHS - MEMORIAL CAMPUS CUMBERLAND If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Dec 3, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 → M 2 □ F Days 216-30-1893 74 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State ral", or items 23a or 28a-f show Exercines must be notified at WV -Mineral Ridgeley 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Rt. 1 Box 344 26753 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: white 3 Midowed 4 Divorced IZ Sirver.
th and Mental Hygjene.
27 is marked other than "natural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer Bethlehem Steel Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin F. Imes, Sr. Violet Imes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Box A 13 Sixth Avenue Cresaptown MD 21502 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau once. Box A 13 Sixth Avenue Alan Imes son Cresaptown 20c. Location - City or Town, State Date Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glendale Cemetery 9/5/2009 MD Flintstone 4 ☐ Donation 5 ☐ Qther (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature Funera Service Lyense 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the ., sease, r . omplica shock, or he .rt .allure. Us only one .lmmediate Cau & f. inal disease or con .ftir n resulting in de th. Approximate Interval Between Onset and Death ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. wank Physician aram neshi /Medical Due to (as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Divide (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 1 □ Yes 2 □ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2ДNo 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier D36766 30. Name and address of pe n who completed cause of death (Item 23a) (Type, Print) POONAI, VIKRAMADITYA, M.D., 924 SETON DRIVE, CUMBERLAND, MD 21502

State Registrar

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No._ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month - 20 **Physician** 19:06 M Jones /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death
PYINCE 4b. City. Town, or Location of Death **Examiner** GEOVARS bouthern maryland HOSDIta Clinton 5. Social Security Number 230-18-934 6. Sex If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Hours Min 1 □ M 🛂 F Days **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location show 10d. Inside City Limits 1 Yes 2 No traumatic event, the Medical Examinar must be notified Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō filed within 72 hours after death with 7420 mariboro 43 23a Funeral items ; 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ō 1 □Yes WNo If Yes, Give Year or Dates: Specify þ BIOCK Widowed 4 □ Divorced Specify: "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NQT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental unnie ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Idaughter</u> washing ton, 3+3E#303 5011 27 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Riverdale. Riverclale Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 814 UDSNUR ST NW WOSH, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hyperkalem. Physician disease or condition resulting in death) /Medical Due to fall as a consequence of): Examiner RESPIRATION Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Sepsis and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 No Day Year Month 5 Other (specify) the detached 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy perforn certificate 1 ∐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician: The Hospital or Attending death. after death. To the Hospital of within 24 hours at To the Funeral D

Maryland 21215-0036

Baltimore,

State Registrar (Check only

29b. Signature and title of certifier

one

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

AUG 2 6 2009

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 09120109

Examiner

R	Division of Vital Records, P.O. Bo
To the Hospi within 24 hou To the Funer completely fill	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attencompletely filled in by the funeral director, page 2 should be detached for tun.

	For State		State of	Marylan	-	artment of H <i>rtificate of L</i>		Mental Hy		C. C. V. F.	00077	
	Registrar 1. Decedent's Name	e (First, Middle	e, Last)			Timeate of I	Jean	2. Date of De			3. Time of Death	
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aminer			n, give street and numb	per)		, ,	Location of Death	ı	4c.	County of Death	_	
	5404 Patterson Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Un						erdale If Under 24 Hrs.	8. Date of Bi	rth		George's	
eral ctor	214-12-7	543	1 □ M 2 🛛 F	95	Yrs.	Months Days	Hours Min.	October	ay, Year)	913 Lou:	nplace (State or Foreign untry) Isa, VA	
ta	Usual Residence of 10a. State	10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits	
once. To Be Completed by Funeral Director	Maryland	Princ	e George's	R	iverda	le					1⊠Yes 2 No	
Director	10e. Street and Nur	nber				10f. Zip Code			10g. Cit	izen of What Cou	untry?	
rail	5404 Pat	terson	Road				20737			USA		
by Funeral	11. Marital Status1 ☐ Never Marri3 ☒ Widowed		12. Was Decede Armed Force ied 1 ☐ Yes 2 If Yes, Give Year or Date	es? ⊠No	- 1	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ☒ No	ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	0-	14. Race - Amer Black, White Specify: W		
ted	(0	15. Deceden	t's Education		16a. Dece	dent's Usual Occup	ation		16b. Kind of Business/Industry			
ompleted	Elementary/Second 12	ndary (0-12)	st grade completed) College (1-4	or 5+)		kind of work done of DO NOT use retired ssing Gua		King		fic Safety ce George'	Division s Government	
Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vocabet i Harilous											
10	Thomas E. Houchens Vashti Harlow											
	19a. Informant's Na					ng Address (Street a					ip Code)	
			/ Daughter	20h Pl	L	Pattersor					own State	
	20a. Method of Disposition 1 Ma Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Fort Lincoln Cemetery 8/27/2009 Brentwood, Mary											
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a, Part 1. Inter the pass se, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate											
	23a. Part1. Inter the less se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Pulmonary Disease Years											
	resulting in death)			as a consequ								
Examiner	Sequentially list conditions, D. Due to (or as a consequence of cause, Clisease or injury that initiated events resulting ideath.) Last											
edical Ex	resulting in death) Last Due to (or as a consequence of): d.											
	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery											
hysician/M	23b. Was decedent in the past 12 1 ☐ Yes 2 2 ☐ Unknown	months?	1 Live bir	th 2 ☐ Fetal nt at time of de	death 3	☐ Ectopic pregnancy ☐ Other (specify)	<i>y</i>			23d. Date of deli Month	very Day Year	
by P	Part II. Other signif	icant condition	ons contributing to deal	th but not resu	Iting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco i	use contribute to	the cause of death?	
	_Hyperter	sion						1 🗆	Yes 2	No 3□ Pro	obably 4 🗌 Unknown	
Completed	Peripher Dementia		cular Dise	ase wit	th Gan	grene Fee	t	24a. Was auto perfe 1 □ Yes	psy ormed?	prior to death?	topsy findings available completion of cause of	
Be C	25. Was case referr examiner?						26. Place of Dea			1 1 163	2 110	
2	1 ☐ Yes 2 🔀			oatient 2 🗆 l			4 Li Nuising n	lome 5 🛚 Res	idence	6 □Other (Spec	cify)_	
ertification:	27. Manner of Death 1 Natural 2 Accident	5 ☐ Pendin investig	jation	Injury Day, Year)	28b. Time o Injury	Work	yat (? Yes 2 □ No	28d. Describe	how injur	ry occurred		
Certific	3 ☐ Suicide 4 ☐ Homicide	6 Could r determ	ined 200. Flace of	Injury - At ho , etc. <i>(Specify</i>	me, farm, str	eet, factory, office		28f. Location (City or To			ral Route Number,	
edical	29a. Certifier (Check only one)	1 X Certifyin 2 Medical	g Physician: To the base Examiner: On the base and manne	is of examinat	wledge, deat ion and/or ir	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occu	e, and due to the urred at the time	cause(s , date and) and manner as d place, and due	stated. to the cause(s)	
Σ	29b. Signature and title of certifier D2 2549 29c. License number D2 29d. Date signed (Month, Day, Year) 8/24/2009											
	Ghulam M	lohi-Ud	who completed cause -din, 6510	Kenil _v	vorth		uite #26	00, Riv	erda	le, MD 2	20737	
tate trar	AUG 2	h, Day, Year) 3 2009	Server >	gistrar's Signat	ure							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day LEON RICHARD **JAMES** 22, AUGUST /Medical 2009 \mathbf{P}^{M} 4:25 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1) DEC. 25 9. Birthplace (State or Foreign 1 XM 2 ☐ F Months Days Hours 217-42-7828 Director MARYLAND 66 DEC. 1942 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2 No MD PRINCE GEORGE'S CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6713 SEAT PLEASANT DRIVE must 20743 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No It Yes, Give Year or Dates I ETNAM FRA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∐ Yes 2 X No þ BLACK 3 Widowed 4 Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MAIL CLERK GOVERNMENT it of Health and Mental Hyg if item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) RICHARD JAMES ပ MARY FLETCHER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 FRANCES JAMES/WIFE 6713 SEAT PLEASANT DRIVE CAPITOL HEIGHTS, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important; if any injury or once, MD VETERANS CEMETERY 9/1/2009 4 ☐ Donation 5 ☐ Other (Specify) CHELTENHAM, MARYLAND Signature of Juneral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions, if any leading to initial data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to (or as a consequence of): Examine To the Hospit I or Attending Physician: The law requires that the death certificate be executed DIABETES MELLITUS TYPE II burial-tran Due to (or as a consequence of): ding physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No performed? 1□ Yes 24 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2[XNo ဥ 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certification: Date of Injury After 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred X Natural (Month, Day Year) 5 Pending investigation Injury 2 Accident M 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760. Division or Vital Records, P.O.

Baltimore, Maryland 21215-0036

within 24 hour after death.

To the Funeral Director /
completely filled in by the fi

State

31. Date filed (Month, Day, Year)
AUG 2 6 2009

29b. Signature and itle of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATALIE M. VASSALL, M.D., VAMC 50 IRVING STREET NW, WASHINGTON, DC 20422/688

32. Registrar's Signature

Registrar

Medical

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

MD# 035846

29d. Date signed (Month, Day, Year)

AUGUST 25, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 08 2000 /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner O. tol Center if Under 24 Hrs/ 8. Date of Birth
Mini (Month, Day, Year) If Under 1 Year 9. Birthplace (5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F Yrs. 250**-**04-1534 53 09-06-1955 Director SOUTH CAROLINA Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: if fem 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modesi Exercition must be northed any injury or other traumatic event, the Modesi Exercition must be northed. 1XIYes 2 ☐ No Director MD PRINCE GEORGE CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5604 LARSON COURT 20743 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify. Specify: BLACK <u></u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12th PAINTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH BERNARD JOHNSON HETTIE E. LATTAKER ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MAMIE Y. WILLIAMS/FRIEND 5604 LARSON COURT CAPITOL HEIGHTS, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE CREMATORY 08-25-2009 4 ☐ Donation 5 ☐ Other (Specify) RIVERDALE, MD 22. Name and Address of Facility JB JENKINS FUNERAL HOME 21. Signature of Funeral Service Lidensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the dis-/se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fail if e. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-traresulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Vital 1 ∐ Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1☐ fes 2☐ No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Division of Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after oc. 1 Natural 5 Pending 2-09 2 No investigation 1 ☐ Yes 2 Accident he Could not be 28e. Place of injury - A home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Str. City or Town, (Street and own, State) determined 4 Homicide SIrec podu 24 hours e Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) AUG 2 7 2009

32. Registrar's Signature

CARNELL COOPER, MD 3001 HOSPITAL DRIVE CHEVERLY, MD 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certificate of Death

4b. City, Town, or Location of Death

Severna Park

2. Date of Death Month

Aug.

Day

15,

Year

Anne Arundel

Maryland

14. Race - American Indian, Black White etc.

White

2009

4c. County of Death

USA

Specify:

Home

23d. Date of delivery

29d. Date signed (Month, Day, Year)

SELERIVA PARK, MD

Day

24b. Were autopsy findings available prior to completion of cause of

death? 1 □Yes 2 □No

Month

and manner stated.

31

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KAT

AUG 20

3. Time of Death

10:35 A

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

UNKYOUN

years

Year

1 □Yes 2 No

	F	tegi	strar	
рнмн	17	Rev	1/2001	

State

145

29b. Signature and title of certifier

STEPHEN

31. Date filed (Month, Day, Year,

1 - State Registrar

Physician

/Medical

Examiner

1. Decedent's Name (First, Middle, Last)

Suzanne Aleathea Jacobson

4a. Facility Name (If not institution, give street and number)

RUPYO

RUBIN SON

within 2

0

Baltimore, Maryland 21215-0036

68760.

Box

P.O.

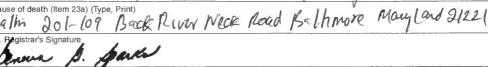
Division of Vital Records,

State Registrar

31. Date filed (Month, Day, Year)

Rameeh

29b. Signature and title of certifier



201-109

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sabapalhi

29c. License number

August 13 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Margaret S. Jurf p^M 2009 8:00 22 <u>August</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□M 25€ Months Days Hours ALA 215-36-2908 June 18 1935 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director MD Carroll Westminster 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 829 Franklin Avenue 21157 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedo... Armed Forces? ¹ □Yes 2 XNo 1 ☐ Never Married 2 Married 1 ☐Yes 2 X No Specify: If Yes, Give Year or Dates \$ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Art Teacher Baltimore Co Schools 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Freeman ည Erwin H. Simon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 829 Franklin Avenue Westminster, MD Amin N. Jurf/husband 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 08/2872009 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Suitland, MD Signature of Funeral Service Printer and Chapel, P.A. V 412 Washington Road Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 Unknown Be Completed by

Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760 physician the attending pl signed by the a d be detached for ficate has been sign', page 2 should b certificate

: After this certification and areas and areas are the section. hours after death uneral Director: death. filled in by the

Examiner

Funeral

Director

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, Its. Modical Examination in mission of the confilted at

iene.

Health and Mental Hygiem 27 is marked other

permit. Pages 1 and Department of Healt Important: If item 27 any injury or other to once.

Physician

/Medical

Examiner

Examiner

Physician/Medical

Certification: To

Medical

State Registrar

and 2 should be

72 hours after

Maryland 21215-0036

Baltimore,

within 24 hours a

To the Funeral D completely မ NJL 20

Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Onknown
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	ne 5 Residence 6 Other (Specify)
27. Man of Death 1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	on (Month, Day, Year) Injury Work? M 1 Tyes 2 No	8d. Describe how injury occurred 8f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying P	hysician: To the best of my knowledge, death occurred at the time, date and place, a miner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	when My 29c. License number 399.	29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)

iM De

Flavio Kruter,

31. Date filed (Month, Day, Year.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Cecelia Booth Kelso 9:30 /Medical ам Aug 22 2009 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 M 2 TF Months Days Hours 15 92 Director 223-16-1435 Yrs 1917 Virginia Usual Residence of Decedent 10a, State 10b. County 10c, City, Town or Location 28a-f show 10d. Inside City Limits Examiner must be notified at Director VA 1 X Yes 2 □ No Alexandria 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with օ items 23a 206 E. Nelson St Funeral 22401 USA 12. Was Decédent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Experiment Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Duplicating Printing 17. Father's Name (First, Middle, Last) æ 18. Mother's Name (First, Middle, Maiden Surname) Wade H Salmon ပ Ida Beck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lulu Bates daughter 3144 Applecreek Lane, Waldorf, MD 20603 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Preddys Creek Date 20c. Location - City or Town, State Buriai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/27/09 Barboursville, VA Baptist Cemetery 21. Signature of uneral Service. 22. Name and Ad ress of Facility Everly Wheatley Funeral Home 7. Oc 1500 W. Braddock Road, Alexandria, Va 22302 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical ANDIOUASCUZAA MISAKE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical use as led by the attending I detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Ye ar P.O. 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐Yes 2 No 1 ☐Yes 2 ☐No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attanding 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident the 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled Hospitai 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier ress of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Backer

12070

32. Registrar's Signature

Month, Day, Year) AUG 2 6 2009 OLD LINE CENTER WALDONF, M. 2500

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ам Arthur R. Kelton 08-22-2009 1:50 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last hirthday 8. Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min 1**⊠** M 2□ F 577-50-3763 70 Director 12-20-1938 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in than "natural", or items 23a or 28a-f shorthe Medical Examinar must be notified at 1 Yes 2 No Director MdPrince George Takoma Park 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 8 Philadelphia Avenue 20912 USA death y Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 \$ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Black 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Carpenter Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Kelton Bernice Johnson ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Sligo Ave., #404, Silver_Spring, Md 20910 Earl Kelton / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; if Ite
any Injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville 4 ☐ Donation 5 ☐ Other (Specify) 08-31-2009 Parklawn Cemetery 21. Signatura of Funeral Service Lice 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Lun Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be executed sician and burial-trans Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. 1 Tyes 2 No. 9 Unknown þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 certificate has autonsy perform of Vital 2K No 1 ☐ Yes Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify Hospice IP) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1X Natural 2 Accident 5 Pending investigation ours after death.

neral Director: Af
filled in by the ful 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 6 Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the within 2 and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 163748 J. Kouch hou August 26,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 6001 Muncaster Mill Rd., Rockville, Md 20855 Jocelyne Kouatchou,

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician PM William ua Keller 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington Hagerstown 8. Date of Birth (Month, Day, Year) Nov. 25, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1X M 2□ F 234-38-8249 Director 1926 West Virginia 82 Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits show Director 1 √ Yes 2 No ed other than "natural", or items 23a or 28a-f event, the Medical Examinar must be notified MD Washington Hagerstown s 1 and 2 should be filed within 72 hours after death with the Inf Health and Mental Hygiene. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 728 Chestnut St. U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 ☐ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify <u></u> Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Maintenance Truck Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Donahue George Keller ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Nye/Son-In-Law 10913 Tennebrook Rd., Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If itel any Injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/28/2009 Rest Haven Cemetery Hagerstown, MD 21. Signatur f Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 2 disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical law requires that the death certificate as attending properties of the second IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) signed by the a P.0. 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? cate has t page 2 s 24a Was an autopsy The this certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 1 Impatient After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: ocompletely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated

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To the I within 2

th, Day, Year, 31. Date filed (Month,

ARIO

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

MED

State Registrar 29c. License number

5060396

Deal

Hoge rstown

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Honth **Physician** 200° SOOA M KALIVUNA 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stavarsville Kryug bren Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 K Months Days Hours Min Director 071-14-3611 87 NEW YORK AUGUST 5, 1922 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evertings must be consequent. 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MARYLAND QUEEN ANNE'S STEVENSVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 305 KEENE FARM LANE 21666 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian Black, White, etc. 11. Marital Status Armed Forces 1 Never Married 2 Married 1 ∐Yes 2 **X** No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 😿 No Specify: \$ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LAWRENCE BONANNI ETHEL BOMBARA ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTHONY L. KALIVODA/HUSBAND 305 KEENE FARM LANE, STEVENSVILLE, MARYLAND 21666 20b. Place of Disposition (Name of cemetery crematory of other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State AUGUST 4 ☐ Donation 5 ☐ Other (Specify) CREMATION CENTER STEVENSVILLE, MARYLAND 2009 21. Signature of Euneral Service Licensee FELLOWS. HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MI **Physician** 1129 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner S1440501 Hortz-Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami sician and burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s autopsy performed 1 ☐ Yes 2 □ No 2 1 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural 5 Pending Injury death. ours after death neral Director: / 2 Accident investigation 1 □Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I Medical 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune (Check only

Registrar

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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and manner stated

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8067

2009

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Augistes

29d. Date signed (Month, Day, Year)

08/25/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** <u>Soon Im Kim</u> /Medical 08 2009 1:58 Р 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Spring If Under 24 F Silver Montgomery 9. Birthplace 5. Social Security Number 7. Age (In vrs. last birthday) (State or Foreign **Funeral** Date of Birth (Month, Day, Year) Birthplace Country) 1 □ M 2 🔀 F Months Days Hours Min. Yrs. Director 81 March 1, <u> 225–29–8374</u> 1928 South Korea Usual Residence of Decedent 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Nedical Examines must be notified as any injury or other traumatic event, the Nedical Examines. 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No VA Fairfax Burke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9608 Old Keen Mill Rd. #405 Funeral 22015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 ★ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Asian Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Hotel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be In Kyu Paik Ur Jin Hong ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myong A. No / daughter 6232 Jean Louise Way, Alexandria, VA 22310 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fairfax Memorial Pk. 08/19/2009 4 ☐ Donation 5 ☐ Other (Specify) Fairfax, VA 22. Name and Address of Facility National Funeral Home 21. Signature of Fureral Service Licensee. M00910 7482 Lee Hwy., Falls Church, VA 22042 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of): **Examiner** Septic Shock Sequentially list conditions, if any, leading to immediate cause. Entry Clause (Disease or injury that initiated events Examine Due to (or as a consequence of) Respiratory Failure resulting in death) Last Due to (or as a consequence of): burialphysician at the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖺 No Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 □Yes 2 🗆 No 24 XNo 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2√XNo Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \Bull Nursing Home Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 2 Accident 1 ☐ Yes 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital 4 hours after death. the filled in by within 24 hours a

To the Funeral I

Completely filled 8

certificate

Baltimore, Maryland 21215-0036

Box 68760

P.O.

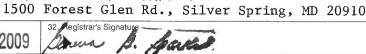
Records,

State Registrar

31. Date filed (Month

29b. Signature and title of certifier

Nejib Siraj MD



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

29c. License number

D0068150

29d. Date signed (Month, Day, Year)

August 15, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Peter Lawrence Kleberg

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Physicia		1. Decedent's Name (First, Middle	,Last) Peter	Laurenc	e Kleb	era			Date of De	ath		- (3. Time of Death
Medical Exami	ner	Peter Lawrence	Kleberg			01 9			Month August 2	Day 5, 20 0	Year		0730 hrs
		4a. Facility Name (if not institution		er)	4	b. City, Town, or L	ocation of				c. County of	Death	
		3307 Ferndale Street				Kensington				I	Montgom	ery	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. las	t birthday)	If Under 1 Year	If Under	24Hrs. 8	. Date of B	irth(MM	/DD/YYYY)	9. Birth	place (State or
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th with th	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U.S	. 13. Was	Decedent of Hisp	anic Origi	in? (Specif					an Indian, Black,
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112 Id be Menta nark	To Be	Marcellus Alexa 19a. Informant's Name/Relationsh		rg	10h Mailing						Nite of Taylor	D1-1-	75- O- d-)
MD 2 d 2 shou tth and N n 27 is n	F	 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Theresa Canniff, Executrix 8701 Irvington Avenue, Bethesda, MD 											
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Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service L	icensee	ICTE	22 Na	ame and Address	of Facility	_					
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Physician		23a. Part I. Enter the disease, or o	complications that caus		o not enter the	e mode of dying, s	uch as ca	rdiac or res	spiratory ar	rest, sh	ock, or hear	t I	Approximate Interval
/Medical		failure. List only one cause of		-		-						- 1	Between Onset and Death
₹xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co			diovascu	ılar	Disea	ise			\rightarrow	Death
4. ™ 4			bue to (or as a co	insequence or).									
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of):								\neg	
	Examiner	(Disease or injury that initiated	c.									170	
ات ہا	Xa	events resulting in death) Last	Due to (or as a co	nsequence of):									
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed reath. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transit			1 d										
oe exician	n/Medical	X UNPENDED	X AMENDED Z	3a,e,pt	BMM M	per/me	8 896	10-1 er M	689 9-089	3t9/	/10/09	TT	
8760, iificate bing physic	₹	IF FEMALE:	23c. If yes, out	come of pregna	incy					23	d. Date of d	elivery	
687 ertific ding	an/	23b. Was decedent pregnant in the past 12 months?	LIVE DITTI	1	2 Feta	al death 3	Ectopic	pregnancy	,		Month	Da	ay Year
Box 68 e death certi the attendin ed for use a	Sici	1 Yes 2 No 9 Unkr	10110	at time of deat	h 5 Oth	er (Specify)							
Box 687 ne death certific the attending ped for use as the	Physicia		9 unknown										
P.O.	by	Part II. Other significant condition		eath but not res	ulting in the ur	nderlying cause giv	ven in Par	t I.					ne cause of death?
F, P.C ires that signed I	9	Smoking, Dia	betes					8	1 X Ye	es 2	_ No 3 _	Proba	ably 4 Unknown
ords	Completed								24a. Was				opsy findings available
CO e law e has	티					-			auto perfe	psy ormed?		or to co	mpletion of cause of
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n of Vital Recing Physician: The L	의	1 ✓ Yes 2 No	ттра		R/Outpatient			Nursing H	ome 5	Reside	ence 6 🗸	Other: 5	Scene
ing Ph	ij	27. Manner of Death	28a. Date of I (Month, Da FOUND:	v Year)	8b. Time of In				d. Describe	how inj	ury occurred	t	
ision Attend r death. ector: by the i	읥	Natural 5 Pendir 2 Accident Investi	ng FOUND: igation Aug 25, 20		FOUND: 0715 hrs	1 Ye	es 2 i	No					
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should t	ertification	3 Suicide 6 Could	28e Place of	f Injury - At hom	ne, farm, street	, factory, office bui	ilding, etc	. 28f			and Number	or Rura	al Route Number, City
pital O	F	4 Homicide determ						Unl	or Town, known	State)			
Division Hospital or Attent 24 hours after death Funeral Director:	ख	29a Certifier	rsician: To the best of	my knowledge	, death occurre	ed at the time, date	e and plac	ce, and due	e to the cau	se(s) ar	nd manner a	s stated	d.
thin the mple	:		iner: On the basis of e		l/or investigation	on, in my opinion, o	death occ	urred at the	e time, date	and pla	ace, and due	e to the	cause(s)
	8	29b. Signature and title of certifier	and manner state	7/100	241	29c. License	number			29d.	Date signed	(Mont	th, Day, Year)
THE PARTY OF THE P		Jato 0/1.	the In	16	1	O.C.M	I.E.			Α	igust	26	2009
′		20 Name and oddies	The service of	d death the	0-1					Au	-6uat		2003
		 Name and address of person was Assistant Medical E: 		of death (Item 2) Penn Street,	,	MD 21201							
St: Regist	State 31. Date filed (Month, Day, Year) 32. Registrar's Signar fre parks.												
	_			7	* #								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item # 8 State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Cecil Co. 09/01/09 rw Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** p^{M} 23, August 2009 6:50 Joseph Leonard Kramer, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cecil Elkton Care & Rehabilitation Center Elkton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yela 935 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **X**□M 2□ F 218-30-5839 75 20 Dec. Maryland **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at YYes 2□No Director Maryland Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 345 Broad Street 21903 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: Completed by 3 Widowed 4 □ Divorced White "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore Animal aryland 2121 filed within Hygiene. Elementary/Secondary (0-12)
Six Years College (1-4or 5+) Shelter Important: If item 27 is marked other tha any injury or other traumatic event, the I once. Animal Control Officer Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Bertha LeBon Charles Kramer ျှ and I 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Pages 1 and ment of Health and 27 lf Sherry L. Phillips (Daughter) 30 Arthur Avenue, Port Deposit, Maryland 21904 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XI Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/28/09 Hopewell Cemetery Port Deposit, Maryland 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, Perryville, Maryland 21903-07 ture of Funeral Service Licenses 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Und disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed this certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 1 Inpatient 27. Manner of Death 1 Natural 2 ☐ Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗌 Yes 2 🗌 No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

State Registrar DHMH 17 Rev 1/2001 29b. Sign

filed (Month, Day, Year)

AUG 27 2009

1 L

32. Registrar's Signature

and manner stated.

30) Name and address of person who completed cause of death (Item 23a) (Type, Print)

9c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 22991 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ROBERT K. LINDSAY August 2009 3:07 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S LANHAM DOCTORS COMMUNITY HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 09-04-1952 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 11☑ M 2□ F 095-42-9012 56 NEWYORK, NY Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, it a Modical Examinar must be notified at Director MD PRINCE GEORGE ty⊡Yes 2□No LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 6903 LYLE STREET 20706 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? 1▼Yes 2 □ No Armed Forces 1▼Yes 2□ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: ģ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, Ital once. DISABLED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT LINDSAY ပ္ ELAINE MILES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TONIDA LINDSAY/WIFE 6903 LYLE STREET LANHAM, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
RIVERDALE CREMATORY 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 08-28-2009 RIVERDALE, MD 4 □ Donation 5 ☐ Other (Specify) 21. Signature, Funeral Service Lie 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician YSRH disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 🗆 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 No 2 4 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 X ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending death. 24 hours after death Funeral Director: filled in by

death

72 hours after

Baltimore, Maryland 21215-0036

Hospital within 2

State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifie

MDD 5467

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHOBHIT ARORA 8118 GOOP LUCK ROAD LANHAM MARYLAND 20706 Wayne Darryl Lee
09-06387 Please

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK		For State	ate of Mary		partment e <i>rtificate</i>			and	Menta	l Hyg		eg. No.	2.0	I) C	2890
Physician		egistrar . Decedent's Name (First, Middi	e,Last)								Date of Dea Month		Year		of Death
Medical Examine		WAYNE DARRYL	LEE							/	August 1	4, 2009	9		0 hrs
	4	a. Facility Name (if not institutio	n, give street and i	number)		4t	Silevr S		cation of	Death			4c. County of Death Montgomery		
	Ļ	Holy Cross Hospital		1= 1 - 4 - 4	land blade day				If Under	24Hrs I	8 Date of B		DD/YYYY) 9. Bi	irthplace (State or
Funeral Director	5	, Social Security Number	6. Sex	7. Age (In yrs	s. last birthday		If Under Months	Days	Hours	Min.			Fore	ign ountry)	i
Director	L	226-08-2720	1x M 2 F	45		Yrs.					3/9/	54		ouritiy)	VA
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	-	30. Name and address of person	on who completed	cause of death (Item 23a)										
		Donna M. Vincenti,		nt Medical E		111	Penn S	Street,	Baltim	ore, MI	21201				
Sta	ite	31, Date filed (Month, Day, Yea	7) 3	Registrar's Sig	nature	ach	11								
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			Registrar 1. Decedent's Name (First, Middle, Last)		er inicale or i	Jeaur	Reg. No. 2. Date of Death 3. Time of Death					
	Physici /Medio		Willie Mae Lloyd					Day Year				
	Examin		4a. Facility Name (If not institution, give street and no	ımber)	4b. City, Town, or	Location of Death		4c. County of Death				
de			Southern Maryland Hosp			inton If Under 24 Hrs.		Prince George				
	Funeral Director		5. Social Security Number 251–22–0034 6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs. last birthda 90 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye 07/17/19	ar) Sout	place (State or Foreign htry) h Carolina			
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			1	0d. Inside City Limits			
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	r 28a	Director	10e. Street and Number	12.	10f. Zip Code	CIBILED	10g.	10g. Citizen of What Country?				
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Marical Extrair crimat be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 3 Widowed 4 Divorced 12. Was Dec Armed Fi 1 Yes 1 Yes 1 Yes 4 Par or D	orces? 2∏ No ive	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🖾 No	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black				
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58760,	Physician /Medical Examiner building physician and building free prize free physician and the prize free physician and the physician and the physician and the physician physician and the physician	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	(or as a consequence of): (or as a consequence of): (or as a consequence of):	OCADA NOTIC	CARDIO	HACU (TAR DIS	SASE 484			
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Division of Vital Records,	. The law requir cate has been s page 2 should	Completed					24a. Was an autopsy performed	prior to co death?	opsy findings available impletion of cause of			
Ĭ,	Physician: r this certific ral director, I	Be	25. Was case referred to medical examiner?		Oth	26. Place of Deat	(Check only one)					
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	ne Hospit. n 24 hours ne Funera	Medical C	29a. Certifier (Check only one) Certifying Physician: To the land mar	e best of my knowledge, de pasis of examination and/or oner stated.	eath occurred at the till investigation, in my c	me, date and place, pinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due t	stated. o the cause(s)			
	To th withii To th comp	Me	29b. Signature and title of certifier		29c. Licens	e number	29d.	Date signed (Month,	Day, Year)			
			MA		1)-	185	IS AU	GUST 2	5, 2009			
2	6		30 Name and address of person who completed cau	12070 0	e, Print) UNE	CENTE	e WA	DOLF, A	Ad. 20602			
	Sta Registr		31. Date filed (Month, Day, Year) 32. F AUG 2 7 2009	Registrar's Signature	•							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan
Department of Health and Mental Hygiene.

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			1 - For State Registrar				Certificate of			Reg. No.	2000	2000		
	Physici /Medic		1. Decedent's Nam John	ne (First, Middle, Las D. Laf	erty				2. Date of De Amonth Augus	1 Day	2009	3. Time of Death 4, 50 AM		
0	Examir Funeral Director			rewashi Number 6. S	e street and number) NGTON Medical AND MEDICAL T. Ag M. M. 2 F	dical Cel e (In yrs. last bii 72	4b. City, Town, of the GIEN (Thoday) If Under 1 Year Months Days	Λ	Cou	undel Diace (State or Foreign orland				
	Maryland f show	tor	Usual Residence o 10a. State MD	of Decedent 10b. County Anne Aru	ındel	10c. City, Tow	n or Location erna Park			10d. Inside 1 ∐Ye				
	with the N 3a or 28a- at be notifi	al Director	10e. Street and Nu 232 Paw	mber rtucket Co	ourt		10f. Zip Code 2114	16		10g. Citizen of What Country?				
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Madical Evariner must be notified at	by Funeral	11. Marital Status 1 □ Never Mari 3 □ Widowed	ried 2 X Married 4 Div <i>o</i> rced	12. Was Decedent Armed Forces? 1 MYes 2 □ I If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub		pecify Yes or No Rican, etc.)	sor No- tc.) 14. Race - American Indian, Black, White, etc. Specify: White				
Maryland 21215-0036	within 72 ho iene. r than "natur the Medical	Completed	(Spe-	15. Decedent's Ecify only highest gra	ducation ide completed) College (1-4or 5	+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Naval Offic	during most of worked)	king	16b. Kind of Business/Industry Military				
yland 2	should be filed vand Mental Hygie s marked other taumatic event, III	To Be C	17. Father's Name John G.	18. Mother's Nam Harrie	e (First, Middle,									
e, Mar	and 2 sho lealth and m 27 is m her traum		Jean H.	lame/Relationship (Laferty /		23	Mailing Address (Street Pawtucket	: Court Se	verna P	ark, M	ID 2114	6		
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item 3 any injury or other once.		4 ☐ Donation	☐ Cremation 3 ☐ 5 ☐ Other (Specify	/	Atlant	f Disposition (Name of ry, crematory or other pla ic cremator LI	.C	st 18, 2009	Glen	on - City or To Burnie	e, MD		
Ba	Depara Impo any is	1	ame	uneral Service Licer	msso	mco	Barranco & 495 Gov. R	<u>Ritchie Hw</u>	y, Seve	rna Pa	rk Fun rk, MD	neral Home 0 21146 Approximate		
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60,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list co if any, leading to in cause. Enter Unde that initiated event resulting in death)	S 🔳	Due to (or as	a consequence a consequence		haryn	ged (Can	iev			
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<u> </u>	hysicia his cer I direct	To B	examiner?	/	Hospital: 1 Inpatie	ent 2 ER/Ou	utpatient 3 □ DOA Oth	26. Place of Deat her: 4 ☐ Nursing Ho			Other (Special	fy)		
Division of	ending Physician; eath. or: After this certificane funeral director, p	ation:	27. Man or of Deat 1 Natural 2 ☐ Accident	5 ☐ Pending investigation		ry 28b. 1	Fime of njury 28c. Inju Woi	iry at rk?]Yes 2 □ No	28d. Describe	how injury oc	curred			
	to the hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director, to	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	building, etc	c. (Specify)	rm, street, factory, office		City or To	vn, State)		al Route Number,		
:	tne Hosp nin 24 hou the Fune npletely fil	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and during the composition of examination and/or investigation, in my opinion, death occurred at the control of the pass of examination and/or investigation, in my opinion, death occurred at the control of the pass of examination and/or investigation, in my opinion, death occurred at the control of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and during the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and during the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and during the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and during the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and during the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and during the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and during the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and during the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and during the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and during the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and during the pass of examination and/or investigation, in my opinion, death occurred at the pass of examination and/or investigation, in my opinion, death occurred at the pass of examination and/or investigation and during the pass of examination and during the pass of examination and during the pass of examination and during the pass of examinat									ce, and due to	o the cause(s)		
	viti Cor	2	29b. Signature and	orge C	Will	Lo TA	M.D. 29c, Licens	se number		Aug	gned (Month, ust 1	7, 2009		
1	H		30 Name and addr	ess of person who	completed cause of d	eath (tep 23a)	Type, Print) ADS	pital D	rive,	Glen	Bur	21061		
	Sta Registra		31. Date filed (Mon	AUG 20	2009 32. Registra	ar's Signature	pare							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 00 NG 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City/Town, or Location of Death 4c. County of Death Examiner Annapolitan Assisted Living Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 577-30-1671 82 Director 1/17/1927 DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Martical Examiner must be notified at once. 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 618 Beach Drive 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 🛣 No Specify: þ white Specify: 3€XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Gov't Printing Office Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Bair Alva McCandlish 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33933 N. Hampton Circle Frankford, DE 19945 George Gunn Stepson 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 Termation 3 ☐ Removal from State 8/25/2009 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Servin 78 Annapolis, Md 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Qui /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) □Yes 2 No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 1 □ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) NNAPULITAL Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide

Hospital or Attending Physician: he law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, been signed by the should be detached s certificate hat I irector, page 2 s 24 hours after death.

Funeral Director: Atter this certific etely filled in by the funeral director. within 24 hou To the Fune completely fi

Baltimore, Maryland 21215-0036

6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier

(Check only one)

Name and address of person who

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

DEFENSE HIGHWAY AVN APOUS MOZIYO

State Registrar

31. Date filed (Month) 32. Registrar's Signature 2009

NTA W

completed cause of death (Item 23a) (Type, Print)

1

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2200 Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Laura Nancy Laita Day Year 19, /Medical 2009 9:00 August 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1099 Broadview Drive Annapolis Anne Arundel Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 T F Months Davs Hours Min. Director 049-42-5799 60 6/17/1949 Connecticut Usual Residence of Decedent fshow 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show 10d. Inside City Limits Maryland Director Anne Arundel Annapolis 1 ☐ Yes 21 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1099 Broadview Drive Funeral 21409 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐Yes 2 ☐No 3 ☐ Widowed 4 ☐ Divorced Specify: is marked other than "natural", Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) +4 <u>Insurance Agent</u> Insurance 17. Father's Name (First, Middle, Last) Be 1 and 2 should be findered the findered to the 18. Mother's Name (First, Middle, Maiden Surname) other traumatic Frank Xanthis Elizabeth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health au
Important: If item 27 is
any Injury or other trau Dana Brown - Daughter 181 Sherbrook St Unit 2, Bristol, CT 06010 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 8/21/2009 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M Taylor Funeral Home, Inc. Myclin T. Klober 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Money /Medical Due to as a con sequence of) Examiner 10 Sequentially list conditions, if any, leading to immediate cause. Enter urmenying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 No Month 5 ☐ Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 ☐ Unknown Completed 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's 1 Yes 2 No Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) E'LD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Patricia Jett M.D. 2448 Holly Avenue, Suite 100, Annapolis, MD 21401 State Registrar

DHMH 17 Rev 1/2001

			For State Registrar			Maryland	-	artment rtificate				F	giene 🗍 🖟 🤄		8995
7	Physic	ian	1. Decedent's Name		•							2. Date of Dea Month	15, 2009		
	/Medi		Joseph 4a. Facility Name (If I					4b Ciby 3	Tour or	Location of	of Dooth	August	4c. County of		7:45 P M
	Exami	ner			rsing Hom				wie	Location	JI Death		Prince		ges
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	pu ,		Usual Residence of D			10.00						-			
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	with the	I Dire	10e. Street and Numi		Dr.	·		10f. Zip	Code 720				10g. Citizen of Wha	at Country?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any fujury or other traumatic event. I'te Modical Examinar must be notified at ance.	d by Funeral Director	11. Marital Status 1 X Never Marrie 3 □ Widowed 4	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
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Balti	permit. Departn Imports any inju		21. Signature of Fan	eral Savies Lice	ensee		22	2. Name and	d Address	s of Facilit	Rob	ert E. I	Evans Fun ie, MD 20	eral	Ноте
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	ysician: is certific director,	To B	examiner? 1 □ Yes 2 🛣 N		Hospital:	atient 2 🗆 E	R/Outpatier	nt 3 DO	A Othe	r			112	(Specify)	
n of	ding Phy h. After thi tuneral o		27. Manner of Death	5 Pending	28a. Date of I (Month,	njury Day Year)	28b. Time or Injury	28	Bc. Injury Work			Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
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	Sta Registr		OT. Date Hed (MONTA)	AUG 18	2009	www.	B. 1	park							

State of Maryland / Department of Health and Mental Hygiene

			1 = State Registrar		C	ertificate of	Death		Reg. No	2005	289	97
	Physici	an	1. Decedent's Name (First, Middle, La	st)				2. Date of D		v Year	3. Time of	
	/Media		Elizabeth Ja					August	16,	^y 2009 ^{Year}	1:15	Рм
	Examir	ner	4a. Facility Name (If not institution, give	·			r Location of Deat	h		. County of Death		
ed T			9318 Bandera St 5. Social Security Number 6.8		ura la at hirthoda	Lanham	I If Under 24 Hrs	8. Date of B		Prince Ge	eorge's	
	Funeral Director			1	yrs. last birthda Yrs.	Months Dave	Hours Min.	Mar.	av. Year)	1941 New	ntrv)	r ⊢oreign
	land ow		10a. State 10b. County	100	. City, Town or	Location				1	0d. Inside Cit	ty Limits
9	Mary Fed sh	호	MD Prince	George's 1	Lanham					:	1 □Yes	2XNo
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Cit	tizen of What Cour	ntry?	
	h wit	<u>a</u>	9318 Bandera St.			20706			USA			
	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show for Marcel Exp., iiner russ be rediffed at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever Armed Forces? 1	in U.S. 1	3. Was Decedent of H	tispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or N to Rican, etc.)	0-	14. Race - Americ Black, White,		
2	ours	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			1 □Yes 2 X No	Specify:			Specify: Wh	nite	
9800-91212	be filed within 72 ho ntal Hygiene. ed other than "natu event, Iro M. vical	Completed	15. Decedent's En (Specify only highest gra	16a. De (Gi	cedent's Usual Occup ive kind of work done of e. DO NOT use retired	ation during most of wo	rking	16b. Kind of Business/Industry				
7	vithin sne. than '	ם	Elementary/Secondary (0-12) College (1-4or 5+)				d)		Own Home			
	be filed v ntal Hygie ed other i event, II	ပ္ပ	17. Father's Name (First, Middle, Last)	по	memaker	18. Mother's Nar	no (Eirot Middl				
yland	d be fautal	m	Gerald Joseph 1					Ann Ca		•		
<u></u>	2 should be and Menta Is marked araumatic ev	ပ္	19a. Informant's Name/Relationship		19h Ma	ailing Address (Street		_			Code)	
Z Z	nd 2 salth an 27 is 27 is r trau		_ , _ , _	spouse		18 Bandera		anham, i		20706	, 6000)	
altimore,	s 1 al		20a. Method of Disposition	20	b. Place of Dis	position (Name of	- 1	Date		ocation - City or To	wn, State	
	Page nent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			rematory or other place Crematory	, I	/2009	Bal	ltimore,	MD	
<u>=</u>	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic enone.		21. Signature of Funeral Service Licer			22. Name and Addre					110	
מ	B a m P B		Hent			6512 NW Cr		Bowie		20715		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approx									₃ ween
	Physician		Immediate Cause (Final disease or condition Bladder Cancer									Death
	/Medical		resulting in death)	Due to (or as a cor								
	Examiner	<u>_</u>	Sequentially list conditions, b.									
	isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or rijury	Due to (or as a cor	sequence of):							
	xecu and al-trar	xan	that initiated events resulting in death) Last	c Due to (or as a cor	sequence of):							
00/00	e be e	al	d									
00	tificate g phy as the	Medical		d								
J. DOX	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	hysician/M	FEMALE: 3b. Was decedent pregnant in the past 12 months? 1							23d. Date of delive Month	-	/ear
ŗ.	that the the control of the control	Δ.,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute							use contribute to the	ne cause of de	eath?
ecords,	requires been sign hould be	eted by								□ No 3□ Prot	oably 4 🔥∪	Jnknown
ם בי	: The law cate has t page 2 s	Completed						24a. Wa: auto peri 1 ☐ Yes	s an opsy formed? 2 🔼 No	24b. Were auto prior to co death? 1 □ Yes		available ause of
1	ician Sertifi ector,	Be	25. Was case referred to medical examiner?	The section is			26. Place of Dea					
5	Phys this al dir	은	1 Yes 2 No	Hospital:			4 LI Nursing F	ng Home 5 ☑ Residence 6 ☐ Other (Specify)				
5	ding Phys T. After this funeral di	Ö	27. Manner of Death 1X Natural 5 □ Pending	28a. Date of Injury (Month, Day, Yea	r) 28b. Time Injury	/ Work		how injury occurred				
	or Attending Ph ter death. Irector: After th of by the funeral	Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined Street and Number of City or Town, State) 286. Place of Injury - At home, farm, street, factory, office 287. Location (Street and Number of City or Town, State)							nd Number or Rura	Rural Route Number,	
ָ	oital c											
:	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exar	ysician: To the best of my niner: On the basis of examend manner stated.	knowledge, de mination and/or	ath occurred at the tir investigation, in my o	me, date and place pinion, death occu	e, and due to thurred at the time	e cause(s , date and) and manner as s d place, and due to	stated. the cause(s))
1	Vithi To th	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mor							te signed (Month,	Day, Year)	
			mars O. reletz mo. D23743 8/18/200							/18/2009		
7	12		30. Name and address of person who			e, Print)	-			14,2403		
A	4)		Martin Weltz	7525 Greenway		r. Gr	eenbelt,	MD 207	70			
	Stat Registra	te	31. Date filed (Month, Day, Year) AUG 19 2	32. Pegistrar's S	igitature 	/						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State o	f Maryland / D		rtment of F		and M		giene Reg. No. 20	09	20	993	
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Dea	ath Day	Year	3. Time of	Death	
	/Medic		Beulah E. Lovett						August 21,		29 "	7:15	РМ	
	Examir	er	4a. Facility Name (If not institution, give street and nut Anne Arundel Medical	,		4b. City, Town, or		of Death		4c. County		اماما		
	Funeral	_	5. Social Security Number 6. Sex	7. Age (In yrs. last birth	hdav)	Annapol If Under 1 Year		24 Hrs.	8. Date of Birt	Anne		olace (State o	or Foreign	
	Director		201-22-4790 1□M 2□XF		rs.	Months Days	Hours	Min.	Jan. 4	v, Year)	Cour	h Caro		
	pu »		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town										
	f sho	ō		,	or Loc	ation					1	0d. Inside Ci	-	
	the A	Director	MD Prince George's	Bowie		10f. Zip Code				10g. Citizen of V	What Cour			
	3a or	i D E	1606 Palace Lane				716			USA		itry:		
	death	Funeral	11. Marital Status 12. Was Dece	dent Ever in U.S.	13. W	/as Decedent of H Yes, specify Cuba		gin? (Spe	cify Yes or No-	14. Rac	e - Americ	can Indian,		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanting runst be redified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ☐ I ☐ Yes ☐ I ☐ Yes ☐ Grant Or Divorced ☐ I ☐ Yes ☐ Year or Div	2 [Ž No ∕e	1	Yes, specify Cuba □Yes 2⊠No	Specify:		Rican, etc.)	Specify	ck, White, or Bl	_{etc.} .ack		
2-0	72 hc	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working						na	16b. Kind of Bu	usiness/Inc	dustry		
121	vithin sne. than "	ld m	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired) Housekeeper						Hotel					
d 2	filed v Hygie ther i		17. Father's Name (First, Middle, Last)			Houseke		or's Name	(First Middle	Maiden Surnam	(a)			
Maryland	Aental rked o	To Be	unknown Leach						Turner	maiden Sumam	6)			
ary	should ly should	-	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing	Address (Street	and Numbe	er or Rura	l Route Numbe	r, City or Town,	State, Zip	Code)		
χ. Σ	and 2 lealth m 27 i		Yvette Lovett Twiggs / d					owie,	MD 20	0716				
ore e			20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from \$	20b. Place of I cemetery	Disposi , <i>crema</i>	ition (Name of atory or other plac	e) :	Da	ate	20c. Location -	City or To	wn, State		
altimore,	it. Pa irtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)			rematory			2009	Baltimo		MD		
Ba	permit. Page Department (Important: If any Injury or once.		21. Signature of Funeral Service In Insee		1	Name and Address					ne 20715			
	Physician		23a. Part 1. Enter the disease, of complications that constant failure. List only one cause on example of the complex of the cause (Final disease or condition	aused the death. Do no		r the mode of dyin		cardiac or	r respiratory arr	<u> </u>	20713	Approximate Interval Bet Onset and D	ween	
	/Medical Examiner	Examiner	Due to (or as a consequence of):											
	ed sit		Sequentially list conditions, if any leading to immufeit cause. Enter Underlying Cause (Disease or injury											
_	xecut and II-tran		that initiated events	F) ·										
8/60	ficate be executed physician and s the burial-transit	dical E	Due to (or as a consequence of):											
200	ifficate g phy: as the	edic	_d		-									
C. Box	The law requires that the death certific atte has been signed by the attending page 2 should be detached for use as	hysician/Me	in the past 12 months?	come of pregnancy irth 2 □ Fetal death ant at time of death own		Ectopic pregnancy Other (specify)	′			23d. Date Mor	e of delive		ear/	
ν L	gned l	by P	Part II. Other significant conditions contributing to de	ath but not resulting in t	the und	lerlying cause give	n in Part I.		23e. Did to	bacco use contr	ibute to th	ne cause of d	eath?	
0	equire sen si ould t								1 □ Y	s 2 No	3 ☐ Prob	ably 4 □ U	Inknown	
I Kecord	The law r ate has be bage 2 sh	Completed							24a. Was a autops perfori	med? p	rior to cor leath?	psy findings ampletion of ca	available ause of	
N I I a	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place	of Death	1 □Yes (Check only on	<u> </u>	1165	ZZZTNO		
6	Physic this c	0	1 Yes 2 → NO Hospital: 1 → 1	patient 2 ER/Outp			4 LI NU	rsing Hom	e 5 Reside	ence 6 Othe	er (Specify	y)		
	ding Phys n. After this funeral dii	ijon	Table 1		me of ury	28c. Injury Work			8d. Describe ho	ow injury occurre	ed			
IVISION	or Atteneter death irector:	Certification: T	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of building	of Injury - At home, farm g, etc. <i>(Specify)</i>	n, stree		′es 2⊡N		8f. Location (Si	treet and Number. State)	er or Rura	l Route Numi	be <i>r</i> ,	
ָ	= = =		29a. Certifier 1 Certifying Physician: To the	best of my knowledge.	death o	occurred at the time	ne, date an	d place, a	nd due to the o	railee(e) and ma	inner as s	tated.		
	o the Hu vithin 24 o the Fu	Medical	(Check only one) 2 Medical Examiner: On the ba and memory 29b. Signature and title of certifier	isis of examination and/	or inve	estigation, in my op		th occurre		ate and place, a				
•	- > - 0		Ti W	1		100	757	635	_				,	
0	49		30. Name and address of person who completed cause	of death (Item 23a) (Ty	ype, Pr	lier/	Part	com	. 6	Any.	hi.	MO	21401	
	Stat Registra			gistrar's Signature	40	lier/								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LENNARTZ MITSUKO 18:56 PM AUGUST 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 💢 F 228-82-4693 **Director** Dec. 30. 1931 Japan 78 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show rofffled at 1 ☐ Yes 2 No Director Maryland Charles 28a-f Waldorf 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or 3 death \ 2004 Wingate Ct. 20602 Funeral Apt 3 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Examir Baltimore, Maryland 21215-0036 ò 1 □Yes 2 X No Specify Specify: Japanese þ 3 XWidowed 4 □ Divorced "natural" Completed traumatic event, If a Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Residential Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental <u>Ginzo Tanabe</u> ဂ္ဂ Tome Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health : John Lennartz/ Son B566 Pine Cone Circle, Waldorf, Maryland, 20602 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important; If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory Aug. 19, 2009 Waldorf, Maryland 21. Signature of Europeal Service Licenses 22. Name and Address of Facility Huntt Funeral Home MUDIIGO 3035 Old Washington Rd. Waldorf, MD. 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** RESPIRATORY FAILURE 2 DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** ASPIRATION PNEUMONIA 3 DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 3 DAYS The law requires that the death certificate be executed INCARCERATED INGUINAL been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 2 No 1 ☐ Yes 1 ☐ Yes funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) Injury 5 Pending n 24 hours after com.
The Funeral Director: After filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined or A I 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) me E. C RES-000 2009 ornino AUGUST 14 ess of person who completed cause of death (Item 23a) (Type, Print)

BB5 State

31. Date filed (Month, Day, Year) 32. R

E. LOCKE

JAYME

32. Registrar's Signature

4940 EASTERN AVENUE

Registrar

BALTIMORE , MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 13:50 AM 2009 Lynn Gwen /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HICALON 54/13641 If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) curity Number **Funeral** Year) 1 □ M 2 🛱 F Days Hours Min Maryland 1/2/6 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, train and all experiment be redified an 1 □Yes 2 No Director Princess Anne Somerset Muryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 3 and hiptry or other traumatic event, the Medical Eventinat Den and hiptry or other traumatic event, the Medical Eventinat Den and Dinge. 21853 U.S.A. 12411 Chestnut Circle Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Lower Shore Shelter Elementary/Secondary (0-12) College (1-4or 5+) Laborer 5th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carr Jane Edward lake ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O.Box 281, Princess Ame, md 853 ake Sr. - Father Circle Chestnut Edward 12411 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Princess Anne, Mcl. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8-29-09 John Wesley Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility E Ward Funeral Home the Princes Anne, molz83 30639 Hampaen Ave 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Palumonia /Medical to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ne spilato be executed Exami burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed After this certificate I 1 ☐Yes 2 ☐ No 2 NO 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 ☐Yes 2 ☐ No nours after death.

neral Director: A
filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Na Z

09.